93-755

No. _____

In The

Supreme Court of the United States

October Term, 1993

MARY KUHL, BUDDY KUHL, JR., MARNIE K. KUHL,

Petitioners,

v.

LINCOLN NATIONAL HEALTH PLAN OF KANSAS CITY, INC.,

Respondent.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

PETITION FOR A WRIT OF CERTIORARI

JOHN S. BLACK,
Counsel of Record
C. W. CRUMPECKER, JR.
LINDA J. SALFRANK
JAMES A. DURBIN
SWANSON, MIDGLEY, GANGWERE, CLARKE & KITCHIN
922 Walnut, Suite 1500
Commerce Trust Building
Kansas City, MO 64106
(816) 842-6100 (Telephone)
(816) 842-0013 (Telefax)

Attorneys for Petitioners Mary Kuhl, Buddy Kuhl, Jr. and Marnie K. Kuhl

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

I. QUESTIONS PRESENTED

1. Whether the preemption doctrine of the Employee Retirement Income Security Act of 1974 (ERISA), at 29 U.S.C. § 1144(a), and this Court's decisions interpreting that provision, compel the preemption of state law claims which arise when an HMO undertakes the medical care of a patient/member (which includes the cancellation of a scheduled medical procedure), dictates the timing and location at which medical care is to be rendered, and disregards the medical advice and recommendations of the patient/member's treating physicians and specialists?

2. Whether the courts below, in considering the defendant's Motion for Summary Judgment, failed to employ the standards and presumptions dictated in previous decisions of this Court when they improperly rejected the evidence averred by the non-moving party and drew inferences in the light most favorable to the movant?

II. TABLE OF CONTENTS

Page

I. QUESTIONS PRESENTED i

II. TABLE OF CONTENTS ii

III. TABLE OF AUTHORITIES iii

IV. JURISDICTION 1

V. STATUTORY PROVISIONS INVOLVED 2

VI. STATEMENT OF THE CASE 2

VII. REASONS FOR GRANTING THE PETITION ... 9

A. The Eighth Circuit and the District Court Erroneously Determined that an HMO's Decision to Cancel a Patient/Member's Life-Saving Surgery, and Other Acts, were "Related to" the Administration of Benefits 9

B. The Purpose of ERISA is Not Furthered by the Eighth Circuit or District Court Decisions 14

C. This Court Has Authority to Protect the Goals Espoused in Creating ERISA 20

D. There is Confusion Among the Circuit Courts on the Issue of Preemption of Emotional Distress Claims 21

E. In Considering the Defendant's Motion for Summary Judgment, the Courts Below Failed to Accept as True the Evidence Averred by Plaintiffs and to View All Inferences in the Light Most Favorable to Them 22

VIII. CONCLUSION 26

TABLE OF AUTHORITIES

Page

CASES

Abofreka v. Alston Tobacco Co., 341 S.E.2d 622 (S.C. 1986) 10

Aetna Life Ins. Co. v. Borges, 869 F.2d 142 (2d Cir. 1989) 10

Amos v. Blue Cross-Blue Shield of Ala., 681 F. Supp. 1515 (N.D. Ala. 1988) 18

Anderson v. Liberty Lobby, Inc., 477 U.S. 242 (1986) ... 23, 25

Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) 23

Cathey v. Metropolitan Life Ins. Co., 805 S.W.2d 387 (Tex. 1991) 17

Clark v. Coats & Clark, Inc., 865 F.2d 1237 (11th Cir. 1989) 10

Corcoran v. United Health Care, Inc., 965 F.2d 1321 (5th Cir.), *cert. denied*, ___ U.S. ___, 121 L.Ed.2d 684, 113 S.Ct. 812 (1992) 12, 13, 20

Drinkwater v. Metropolitan Life Insurance Company, 846 F.2d 821 (1st Cir.), *cert. denied*, 488 U.S. 909, 109 S.Ct. 261, 102 L.Ed.2d 249 (1988) 10, 21, 22

Eastman Kodak Co. v. Image Technical Services, ___ U.S. ___, 119 L.Ed.2d 265, 112 S.Ct. 2072 (1992) 23

Ethridge v. Hader House Restaurant, 861 F.2d 1389 (9th Cir. 1988) 10

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) 20

TABLE OF AUTHORITIES – Continued

Page

Firestone Tire & Rubber Co. v. Neusser, 810 F.2d 550 (6th Cir. 1987) 10

Foltz v. U.S. News & World Report, Inc., 627 F. Supp. 1143 (D.D.C. 1986) 20

Fort Halifax Packing Co., Inc. v. Coyne, 482 U.S. 1 (1987) 10, 15

Framingham Union Hosp., Inc. v. Travelers Ins. Co., 721 F. Supp. 1478 (D. Mass. 1989) 10

Giardiello v. Balboa Ins. Co., 837 F.2d 1566 (11th Cir. 1988) 11

Hospice of Metro Denver v. Group Health Ins., 944 F.2d 752 (10th Cir. 1991) 10, 11, 16

Inland Oil & Transp. Co. v. United States, 600 F.2d 725 (8th Cir.), *cert. denied*, 444 U.S. 991, 100 S.Ct. 522, 62 L.Ed.2d 420 (1979) 26

Johnson v. District 2 Marine Eng'rs Beneficial Ass'n, 857 F.2d 514 (9th Cir. 1988) 21

Jordan v. Reliable Life Ins. Co., 694 F. Supp. 822 (N.D. Ala. 1988) 17

Kane v. Aetna Life Ins. Co., 893 F.2d 1283 (11th Cir.), *cert. denied*, ___ U.S. ___, 111 S.Ct. 232, 112 L.Ed.2d 192 (1990) 20

Lane v. Goren, 743 F.2d 1337 (9th Cir. 1984) 10

Lujan v. National Wildlife Federation, 497 U.S. 871 (1990) 23

Mackey v. Lanier Collections Agency, 486 U.S. 825 (1988) 9

Matsushita Electric Industrial Co. v. Zenith Radio Corp., 475 U.S. 574 (1986) 23

TABLE OF AUTHORITIES – Continued

Page

Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990) 10, 15

Mertens v. Hewitt Assoc., ___ U.S. ___, 124 L.Ed.2d, 113 S.Ct. 2063 (1993) 16, 18, 19

Nat'l Expert Care Consultants, Inc. v. United Airlines, Inc., 1991 W.L. 24387, 59 U.S.L.W. 2588 (S.D.N.Y. 1991) 10

New Orleans Sheet Metal Worker's Local 11 Health & Welfare Fund v. ABC Ins. Co., 1990 W.L. 103118, 18 E.B.C. 1655 (E.D. La. 1990) 10

*Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir.), *cert. denied*, 493 U.S. 1093, 110 S.Ct. 1166, 107 L.Ed.2d 1068 (1990) 16

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) 16

Pizlo v. Bethlehem Steel Corp., 884 F.2d 116 (4th Cir. 1989) 10

Powell v. Chesapeake and Potomac Telephone Co., 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) 21

Psychiatric Institute v. Connecticut General, 780 F. Supp. 24 (D.D.C. 1992) 20

Rebaldo v. Cuomo, 749 F.2d 133 (2d Cir.), *cert. denied*, 472 U.S. 1008, 105 S.Ct. 2702, 86 L.Ed.2d 718 (1985) 11

Settles v. Golden Rule Ins. Co., 927 F.2d 505 (10th Cir. 1991) 11

Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983) 11, 15

United States v. Diebold, 369 U.S. 654 (1962) 23

TABLE OF AUTHORITIES – Continued

Page

U.S. v. Feinstein, 717 F. Supp. 1552 (S.D. Fla. 1989) 26

Uselton v. Commercial Lovelace Motor Freight, Inc., 940 F.2d 564 (10th Cir. 1990) 11

Vilas v. Lyons, 702 F. Supp. 555 (D.N.D. 1988) 10

OTHER AUTHORITIES

Gregory, "The Scope of ERISA Preemption of State Law: A Study of Effective Federalism," 48 U. Pitt. Law Rev. 427 (1987) 18

H.R. REP. NO. 533, 93rd Cong. 1st Sess. 8, reprinted in 1974 U.S. CODE CONG. & ADMIN. NEWS 4639 15

120 CONG. REC. 29,933 (1974), reprinted in the LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (1976) 16

Note, "Blind Faith Conquers Bad Faith" 21 Loy. L.A. Law Review 1343 (1988) 18

JURISDICTION

On December 26, 1991, the Honorable D. Brook Bartlett in the United States District Court for the Western District of Missouri granted defendant's motion for summary judgment and denied plaintiffs' motion to remand, holding that plaintiffs' state law claims were preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq*. A copy of that decision, unreported, is set forth in Appendix C. On reconsideration, Judge Bartlett affirmed his previous order granting defendant summary judgment and denying plaintiffs' motion to remand. The June 15, 1992 affirmance, also denying plaintiffs' motions to alter or amend the judgment and for leave to amend their complaint, is set forth in Appendix D. On June 15, 1992, judge Bartlett also granted defendant's motion to dismiss plaintiffs' second complaint in which plaintiffs sought to alternatively plead causes of action recognized under ERISA for which "other equitable relief" could be recovered. A copy of the District Court's June 15, 1992 dismissal of plaintiffs' second complaint is set forth in Appendix E.

A consolidated appeal was taken by plaintiffs and, on July 7, 1993, a panel of the United States Court of Appeals for the Eighth Circuit issued its decision, affirming the decisions of the District Court. A copy of the panels' opinion, which is reported at 999 F.2d 298, is set forth in Appendix A. The plaintiffs' timely request for rehearing by the Eighth Circuit was denied on August 13, 1993. A copy of the denial of plaintiffs' request for rehearing is set forth in Appendix B. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This case turns on the applicability of the preemptive effect of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C § 1001, *et seq.*, particularly § 514(a) of ERISA, 29 U.S.C. § 1144(a), set out in the Statutory Appendix.

STATEMENT OF THE CASE

These consolidated cases involve whether Lincoln National Health Plan of Kansas City may take deliberate steps, without threat of legal recourse, to undertake the care provided to a member/patient by utilizing its medical decision-making to dictate the care he will receive, rather than providing a simple negative response in answer to a claim for benefits. The cases present the question of whether the HMO may seek the protection of ERISA, after its negligent medical decisions and actions have resulted in death, on the premise that the HMO was simply "administering benefits." The issues presented herein are fact-sensitive and better illustrated with an understanding of the facts, from which these questions arise, as set out below:

On April 29, 1989, Buddy Kuhl, Sr. suffered a heart attack and, with the approval of his designated primary care physician, was placed in the care of Dr. Bernard Levi, a heart specialist at Menorah Medical Center in Kansas City, Missouri. After several weeks of careful examination, tests and care of Buddy Kuhl, Dr. Levi indicated that heart surgery would be necessary, including open-heart LV aneurysmectomy and coronary by-pass surgery. This

recommendation was confirmed by Dr. Ahuja in a second opinion. In a letter setting out that second opinion, dated May 23, 1989, Dr. Ahuja stated that Buddy Kuhl was a "candidate for sudden death" and needed the recommended surgery "in the next few weeks."

Between the dates of June 13, 1989 and June 16, 1989, Buddy Kuhl underwent extensive tests at Menorah to determine the extent of the heart damage and to confirm the proper course of treatment. Dr. Levi instructed Buddy Kuhl that the best course of action was to have the bypass surgery and an aneurysm removal. The surgery was originally scheduled with Dr. Hannah of Kansas City, a heart surgeon at Menorah Medical Center in Kansas City, Missouri. However, after closer review of the test results and consultation with a team of Menorah Medical Center physicians specializing in cardiology, and after consultation with physicians at Barnes Hospital in St. Louis, Dr. Levi determined on June 20, 1989 that, because of Buddy Kuhl's condition known as inducible ventricular tachycardia and his need for computerized mapping, Buddy Kuhl's best chance of survival could be maintained if the surgery were to take place at Barnes Hospital in St. Louis, Missouri. Kansas City area hospitals did not have the equipment to perform the technically-advanced computerized procedure that Buddy needed and the surgeons at Barnes were far more experienced and successful than their counterparts in Kansas City. Therefore, Dr. Cox, a world-renowned heart surgeon, specializing in computerized cardiac mapping and bypass surgery on patients with ventricular tachycardia, was scheduled to perform the surgery with Dr. Cain's consultation.

After discussion with Dr. Cain's staff, Buddy Kuhl selected a July 6, 1989 surgery date at Barnes Hospital, with an admission date set for July 2, 1989. Dr. Hannah, the Kansas City cardiac surgeon originally scheduled to perform the surgery, and a participating provider under the Lincoln National HMO, agreed with Dr. Levi's determination that Buddy Kuhl's best interests would be served by having the surgery at Barnes. He told Buddy Kuhl so on June 21, 1989, and on June 22, 1989 he sent a letter to Dr. Levi to the same effect. Mary Kuhl informed Lincoln National of Dr. Hannah's opinion as well.

Dianne Long, a utilization review coordinator (R.N.) for Lincoln National Health Plan of K.C., received a phone call from Barnes Hospital on June 20, 1989. At that time, Dianne Long learned that the surgery had been scheduled at Barnes. Thereafter, without consultation with Dr. Levi, without consultation with Dr. Cain or Dr. Cox, and without any kind of consultation whatsoever with Buddy Kuhl, Lincoln National made a decision on June 23, 1989 to cancel Buddy Kuhl's surgery at Barnes Hospital.

Lincoln National then took steps to schedule an appointment for Buddy Kuhl to see Dr. Brodine at Research Medical Center in Kansas City regarding the performance of the surgery in Kansas City, rather than in St. Louis, as recommended to be in the best interest of Buddy Kuhl by his physician, Dr. Levi. In fact, the consultation with Dr. Brodine was ultimately scheduled by Dianne Long on June 27, 1989. That appointment (still unbeknownst to Drs. Cox, Cain, Levi or even Buddy Kuhl) was scheduled for the same date as Buddy's surgery in St. Louis (July 6, 1989). The appointment with Dr.

Brodine (mutually exclusive of surgery on the same day) was initiated and scheduled by Lincoln National in direct contravention of the advice and recommendation of Dr. Levi, the cardiac specialist assigned to Buddy Kuhl's care. In fact, when Dianne Long told Dr. Levi (on or about June 23, 1989), that the HMO was considering the possibility of surgery at Research Medical Center, Dr. Levi told her that he wanted Buddy Kuhl's surgery to take place at Barnes Hospital and that the surgeons at Research were "incompetent and inadequate."

Dr. Levi then spoke with Dr. Agee, the Medical Director for the Lincoln National HMO, and told him of the recommendation to have the surgery performed at Barnes and the reasons for that recommendation. Then, on June 23, 1989, Dr. Levi wrote to Lincoln National, in care of Dr. Agee. Dr. Levi advised Lincoln National that Buddy Kuhl needed a special heart surgery which could only be performed by Dr. Cox in St. Louis. Dr. Levi explained that if the surgery was performed by Dr. Cox in St. Louis, Buddy would have an 80-85% chance at survival; if the operation was performed in Kansas City, Buddy's chances of survival were "dismal".

Nevertheless, Lincoln National telephoned Barnes Hospital and canceled Buddy Kuhl's surgery. According to the sworn testimony of Dr. Levi, in cancelling the surgery at Barnes and scheduling an appointment for Buddy Kuhl to see Dr. Brodine instead (all directly contrary to the advice and recommendation of Dr. Levi) Lincoln National literally assumed the care of Buddy Kuhl.

After assuming the role of decision-maker with respect to the care to be provided to Buddy Kuhl, Lincoln National contacted Buddy Kuhl on June 27, 1989. According to his own notes, recorded by Buddy Kuhl in his personal calendar on or about June 27, 1989, "The Ins. Co. called and canceled my Oper. in St. Louis[.] Set up appt. w/Dr. Brodine in K.C. to see about oper."[1]

Dr. Brodine later concurred with Dr. Levi's recommendation (as had Dr. Hannah) that the heart surgery should be performed by Dr. Cox in St. Louis, due to the use of technically-advanced computerized cardiac mapping facilities at that hospital. He spoke with Dianne Long at Lincoln National and conveyed these results to her on July 6, 1989. Nevertheless, Lincoln National waited until July 20, 1989 to call Buddy Kuhl to inform him that the HMO would authorize surgery at Barnes.

Dr. Levi was informed, by copy of a letter written on July 20, 1989, that the HMO was following Dr. Brodine's recommendations and would authorize surgery in St.

---

[1] On July 18, 1989, Buddy Kuhl prepared a letter to his designated primary care physician, Virginia Grimes, setting out his concerns that "the Insurance Company is playing with my life." That letter also tells of how Buddy Kuhl learned that his surgery had been cancelled by the Lincoln National HMO without his advice or consent. The letter reads, in that regard:

> Lincoln National determined that the operation could be performed in Kansas City at Research Hospital. The insurance company arranged an appointment with Dr. Brodine at Research Hospital on July 6th. I was informed of the appointment by the insurance company at which time I was also told that insurance company cancelled my appointment in St. Louis as initially arranged by Dr. Levi.

Louis. That letter also directed Buddy Kuhl that, after surgery, "all hospital care must be rendered by Dr. Levi." Thus, after assuming the care of Buddy Kuhl on June 23, 1989, Dr. Levi has testified that Lincoln National returned Buddy Kuhl to his care on July 20, 1989.

In the HMO's July 20, 1989 letter to Buddy Kuhl, an HMO representative stated that the Health Plan would "authorize [the] surgery" at Barnes Hospital. Buddy Kuhl immediately contacted Barnes Hospital to reschedule the surgery that had been previously canceled by the HMO. Unfortunately, Buddy was informed that the surgery could not be performed until September, 1989 due to the unavailability of the surgical team.

Buddy and Mary Kuhl traveled to St. Louis on September 2, 1989 in anticipation of surgery. However, after tests were conducted at Barnes Hospital in September, 1989, prior to the scheduled surgery, Dr. Cox found that Buddy Kuhl's heart function had deteriorated to such an extent that "I no longer felt he was a reasonable operative candidate. By that I mean, I did not believe [I] could get him through the heart operation alive." As a result, "we recommended to him that he be evaluated for cardiac transplantation because that is really the only thing left to offer." The physicians at Barnes asked that additional testing be done and that Buddy Kuhl be put on a heart transplant waiting list at Barnes Hospital. Lincoln National again refused. Buddy was then put on a heart transplant waiting list at Kansas University Medical Center. Buddy Kuhl died on December 28, 1989 waiting for that heart transplant. The medical explanation for Buddy's death was ventricular tachycardia, the specific

condition for which Buddy Kuhl was originally to receive technologically-advanced treatment at Barnes Hospital.

Thereafter, plaintiffs filed their suit in state court, alleging only state court causes of action. Plaintiffs sought to recover for the tortious conduct of the defendant HMO, by virtue of the acts and omissions of its agents. Specifically, plaintiffs asserted claims for medical malpractice, tortious interference with a contract, and the intentional infliction of emotional distress upon Mary Kuhl. Plaintiffs alleged that the HMO had canceled Buddy Kuhl's life-saving surgery, without the knowledge or consent of Buddy Kuhl and without the knowledge (and against the express advice) of his treating physician, Dr. Levi, and had undertaken to dictate the course, timing and location of Kuhl's medical care. Defendant, rather than addressing the allegations asserted, sought to shield itself from liability under the ERISA preemption umbrella, removed the case and sought summary judgment.

The District Court granted the defendant's Motion for Summary Judgment and denied plaintiffs' Motion for Remand, stating that the plaintiffs' state law claims arose from the "administration of the Plan" and were therefore preempted by ERISA.[2] The Eighth Circuit Panel affirmed the decision of the district court, seemingly for two reasons: First, the Panel believed that Lincoln National's

---

[2] Plaintiffs later filed a motion to alter or amend the judgment, and also filed a second complaint in which they sought to alternatively plead causes of action recognized under ERISA. Plaintiffs' motion to alter or amend was denied, and the District Court dismissed plaintiffs' second complaint.

cancellation of Buddy Kuhl's previously-scheduled surgery, and other acts, did not go beyond the administration of benefits and did not amount to the undertaking of medical decision-making for Buddy Kuhl. Second, the Panel agreed with the district court's decision that the plaintiffs' claims were based on the contention that Lincoln National improperly processed Buddy Kuhl's claim for medical benefits. The Panel found, therefore, that Lincoln National's actions at issue related directly to its administration of benefits, and the lower court's decision, in which the plaintiffs' state law claims were deemed to be preempted by ERISA, was affirmed.

VII. REASONS FOR GRANTING THE PETITION

A. The Eighth Circuit and the District Court Erroneously Determined that an HMO's Decision to Cancel a Patient/Member's Life-Saving Surgery, and Other Acts, were "Related to" the Administration of Benefits

The Eighth Circuit and District Court decisions are inconsistent with this Court's holding that ERISA preemption is not an absolute or universal grant of federal jurisdiction. In fact, this Court has recently decided that ERISA plans may be sued in civil actions and that some state law claims, including tort claims, are not afforded the protection of the complete preemption doctrine established under ERISA. "These cases – lawsuits against ERISA plans for run-of-the-mill state law claims such as unpaid rent, failure to pay creditors, *or even torts committed by an ERISA plan* – are relatively common place." *Mackey v. Lanier Collections Agency*, 486 U.S. 825, 108 S. Ct. 2182, 100 L.Ed.2d 836, 846 (1988) (emphasis added); *See*

also, Memorial Hospital System v. Northbrook Life Ins. Co., 904 F.2d 236, 248-49 (5th Cir. 1990); *Abofreka v. Alston Tobacco Co.*, 341 S.E.2d 622 (S.C. 1986).[3]

Despite its broad construction of § 514(a), this Court has also indicated that it will not extend the "relate to" language to its outer limits. *New Orleans Sheet Metal Worker's Local 11 Health & Welfare Fund v. ABC Ins. Co.*, 1990 W.L. 103118, 18 E.B.C. 1655 (E.D. La. 1990). State

---

[3] Many cases have found tort claims to be outside of ERISA's preemption umbrella. *See, Clark v. Coats & Clark, Inc.*, 865 F.2d 1237, 1243-44 (11th Cir. 1989) (tort claims which had no effect on plan administration were not preempted); *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821, 825 (1st Cir. 1988), *cert. denied*, 488 U.S. 909 (1988) (spouse's claim for emotional distress in connection with harm arising from a benefits denial is not preempted); *Ethridge v. Hader House Restaurant*, 861 F.2d 1389, 1404-05 (9th Cir. 1988) (ERISA did not preempt a claim for tortious discharge, based upon a reference to loss of employment and benefits); *Framingham Union Hosp., Inc. v. Travelers Inc. Co.*, 721 F. Supp. 1478, 1490 (D. Mass. 1989) (involving a claim for accountant malpractice, claims for unfair and deceptive practices which induced purchase, renewal and conversion of insurance policies, and negligent supervision of an agent against the plan insurer, were not preempted); *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990) (hospital was allowed to proceed against an ERISA insurance company and its agent for negligent misrepresentations of coverage). *See also, Nat'l Expert Care Consultants, Inc. v. United Airlines, Inc.*, 1991 W.L. 24387, 59 U.S.L.W. 2588 (S.D.N.Y. 1991); *Lane v. Goren*, 743 F.2d 1337 (9th Cir. 1984); *Fort Halafax Packing Co. v. Coyne*, 482 U.S. 1, 7 (1987); *Hospice of Metro Denver v. Group Health Ins.*, 944 F.2d 752 (10th Cir. 1991); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 556 (6th Cir. 1987); *Vilas v. Lyons*, 702 F. Supp. 555, 563 (D.N.D. 1988); *Pizlo v. Bethlehem Steel Corp.*, 884 F.2d 116 (4th Cir. 1989); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 145 (2d Cir. 1989).

actions which affect plans in too tenuous, remote, or peripheral a manner will not be preempted as a law relating to the plan. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 100, 103 S. Ct. 2890, 2901, 77 L.Ed.2d 490 (1983); *Uselton v. Commercial Lovelace Motor Freight, Inc.*, 940 F.2d 564, 583 (10th Cir. 1990). "ERISA does not preempt claims that are only tangentially involved with a benefit plan." *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991). ERISA preemption provisions surely do not extend to every state law claim that, however remotely, actually involves an employee benefit plan. *Giardiello v. Balboa Ins. Co.*, 837 F.2d 1566, 1571 (11th Cir. 1988). When a state law "does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the law has some economic impact on the plan does not require that the law be invalidated." *Hospice of Metro Denver v. Group Health Ins.*, 944 F.2d 752, 754 (10th Cir. 1991); *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir.), *cert. denied*, 472 U.S. 1008, 105 S. Ct. 2702, 86 L.Ed.2d 718 (1985).

The Eighth Circuit and District Court erroneously disregarded the limitations set by this Court and others on the scope of ERISA's preemptive effect. In the courts below, the plaintiffs demonstrated that the HMO had *undertaken* the care of Buddy Kuhl, and through its representatives, dictated the services to be provided to him, along with the location and timing of those medical procedures. These decisions, on which the plaintiffs' state law claims were based, far exceeded the mere administration of benefits and, while tangentially associated with the employee benefit plan, should not have been deemed

by the courts below to be related to the administration of benefits.

The decision-making at issue herein is a direct result of the fact that HMOs have become immersed in the medical decision-making process. This Court recently denied a petition for a Writ of Certiorari in which the Fifth Circuit highlighted this phenomenon. In fact, in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.), *cert. denied*, ___ U.S. ___, 113 S. Ct. 812, 121 L.Ed.2d 684 (1992), the Fifth Circuit recognized that an HMO is engaged in rendering medical recommendations and making medical decisions. While the *Corcoran* court found that those medical decisions were just "part and parcel" of benefit determinations, the Fifth Circuit also assumed that the HMO's decision-making would affect only the *payment of benefits* for medical services rendered or to be rendered. This aspect of the Fifth Circuit decision, while harsh, is arguably consistent with the law. That is, in *Corcoran*, the patient/member was simply told that the HMO would not pay for the medical procedures her physician had recommended. She then had the option of paying for those services herself and haggling with the HMO for reimbursement at a later date. In *Kuhl*, on the other hand, the HMO's medical decision-making was accompanied by the actual cancellation of the medical procedure recommended, without the member/patient's knowledge or consent and without concern for the immediacy of the patient's need for that medical attention. In so acting, the HMO stripped Buddy Kuhl of the opportunity that was afforded to the plaintiff in *Corcoran* to finance the medical procedure himself. That option was

gone and, ultimately, so was Buddy Kuhl's only chance of survival.

Thus, where, as here, the HMO's medical decision-making is accompanied by deliberate acts which preclude the provision of care to a dying patient, the HMO's medical determinations can no longer be said to be merely a part of the administration of health care benefits. The *Corcoran* decision, and the previous decisions of this Court, do not preclude such a finding. Instead, these decisions confirm that the denial of payment for services is "related to" the administration of benefits. On the other hand, in light of *Corcoran's* recognition that the HMO is engaged in medical decision-making and this Court's dictate that the "relate to" language is not all-inclusive, the HMO exceeds the boundary of merely administering benefits under ERISA when it acts affirmatively to preclude the actual service to be provided to the patient/member and undertakes the medical care to be provided. Under those circumstances, the HMO's actions must no longer be protected by ERISA's preemptive force.

In the decisions below, the Eighth Circuit and District Court failed to limit the application of preemption doctrine to those matters properly "related to" the administration of benefits. The result of that error is far-reaching. The error of stretching ERISA beyond its intended reach is evident in the drastic effects of such an application upon the employees in employee benefit plans and the collateral ramifications on the American health care system. It is clear, of course, that Congress intended to create, through ERISA, a more consistent system of regulating benefit plans. Thus, if § 514(a) of ERISA is properly read to preempt the state law claims which truly "relate

to" the administration of benefits of an employee benefit plan, the goal of a uniform, federal regulatory scheme is fulfilled. If, however, § 514(a) is construed even more broadly to preempt claims which seek relief for acts which are unrelated to benefits, or to the administration of those benefits, the aim of uniformity may be obtained but only at the awesome and devastating expense of the employee and the health care to which he is rightfully entitled.

The Eighth Circuit and the District Court decisions, here, do a disservice to the authors and intended benefactors of ERISA. The decisions exaggerate the scope of ERISA's preemption doctrine to such an extent that an HMO may now make, and act upon, its own medical decisions regarding the care to be rendered to a member/patient, ignoring (without recourse) the recommendations and advice of treating physicians and specialists. Although the HMO's decision-making obviously and tangentially involves a benefit plan, the type of decision-making at issue herein does not involve the payment of benefits, but instead involves the course of medical treatment to be rendered to the member/patient. According to the Eighth Circuit and District Court, that type of decision-making is not subject to state tort law claims. Preemption, dangerously close to absolute in nature, was erroneously deemed by the Eighth Circuit and District Court to protect this type of decision-making.

B. The Purpose of ERISA is Not Furthered by the Eighth Circuit or District Court Decisions

Perhaps the most compelling reason supporting this Court's grant of Certiorari is that the result of the Eighth

Circuit and District Court decisions do not square with Congress' purpose in enacting, and the policies underlying, ERISA. The courts have instructed that "the preemption clause of ERISA must be read in context with the Act as a whole, and with Congress' goal in creating an exclusive federal enclave for the regulation of benefit plans." *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 244 (5th Cir. 1990); *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 8 (1987) (Congressional purpose in enacting ERISA is "ultimate touchstone" of preemption analysis). Thus, where preemption of a state law of general application, viewed in the context of the Act as a whole, does not further Congress' purpose in creating ERISA as a federal concern, the law should not be preempted.

Congress originally enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans." 29 U.S.C. § 1001; *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90, 103 S.Ct. 2890, 2896 (1983); *Memorial Hosp. Sys.*, 904 F.2d at 245. At the time ERISA was passed, it was stated that ERISA's

> . . . most important purpose will be to assure American workers that they may look forward, with anticipation, to a retirement with financial security and dignity, and without fear that this period of life will be lacking in the necessities to sustain them as human beings within our society.

H.R. REP. NO. 533, 93rd Cong. 1st Sess. 8, reprinted in 1974 U.S. CODE CONG. & ADMIN. NEWS 4639, 4646. Senator Javits, one of ERISA's authors and leading proponents, called it "the greatest development in the life of the

American worker since social security." 120 CONG. REC. 29,933 (1974) (statement of Sen. Javits), reprinted in the LEGISLATIVE HISTORY OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (1976).

The Eighth Circuit held that ERISA preempted the Kuhls' state law causes of action.[4] The purported preemptive effect of the federal law, combined with the Eighth Circuit's reliance on this Court's recent decision in *Mertens v. Hewitt Assoc.*, ___ U.S. ___, 124 L.Ed.2d 161, 113 S. Ct. 2063 (1993) (holding that § 502(a)(3) of ERISA could not be construed to provide monetary remedies for a fiduciary's wrongful acts), leaves the plaintiffs with no legal redress for the wrongful death of their husband and father.[5] This result cannot be reconciled with ERISA's

---

[4] The plaintiffs' claims are not ones for plan benefits, but rather tort damages. The claims do not allege improper claim processing; instead, the claims allege medical malpractice, tortious interference with a contract, and emotional distress arising from the negligent acts of medical malpractice.

[5] The preemption decision of the Eighth Circuit shields Lincoln National from liability and leaves the plaintiffs without recourse. Plaintiffs are aware that preemption normally is not dependent upon the availability of ERISA remedies. *See, Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54, 95 L.Ed.2d 39, 107 S. Ct. 1549, 1566 (1987); *but see, Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157, 162 (6th Cir. 1989), *cert. denied*, 493 U.S. 1093, 110 S. Ct. 1166, 107 L.Ed.2d 1068 (1990) (which held preemption only applies when Congress has provided an adequate remedy), *cert. denied*, 493 U.S. 1093, 110 S. Ct. 1166, 107 L.Ed.2d 1068 (1990). The plaintiffs, however, were not participants or beneficiaries as enumerated in the Supreme Court opinion or in the statute itself, and, therefore, their lack of alternate remedies in the event of preemption is deserving of consideration. *See, Hospice of Metro Denver v. Group Health Ins.*, 944 F.2d 752, 755 (10th Cir. 1991).

broad remedial purpose to benefit employees and their beneficiaries, such as the plaintiffs. No conceivable federal interest, nor any purpose for which ERISA was passed, is served by allowing ERISA to act as a shield to protect professed medical professionals from tort responsibility when they interject themselves into the medical decision-making process and undertake the care of the patient/member with disastrous results. To do so turns an act passed to benefit workers on its head, and transforms it into a weapon to deprive them of rights.

Many courts and commentators have expressed concern that an overbroad application of § 1144(a) unnecessarily deprives workers of traditional rights and remedies. For example, in *Cathey v. Metropolitan Life Ins. Co.*, 805 S.W.2d 387 (Tex. 1991), the Texas Supreme Court dismissed the plaintiffs' state law misrepresentation claims as preempted by ERISA § 514(a). Justice Doggett, joined by two other justices, ruefully concurred in the dismissal, noting that through an ever-widening use of the preemption clause, "a statutory addition to workers' rights has been converted into a statutory removal of those rights." *Cathey, supra.* He continued:

> . . . the workers ERISA was intended to protect lack a remedy for wrongs unaddressed by the statute, while the companies targeted by Congress employ ERISA as an effective shield against responsibility for wrongful claims processing. . . . Under ERISA, insurers who provide group benefit plans have little incentive to deal promptly and fairly with employer participants.

Cathey, supra. See also, Jordan v. Reliable Life Ins. Co., 694 F. Supp. 822, 827-36 (N.D. Ala. 1988) (ERISA has become

"quicksand" that will "continue to expand and preempt everything in its meandering path"); *Amos v. Blue Cross-Blue Shield of Ala.*, 681 F. Supp. 1515 (N.D. Ala. 1988) ("If the recognized purpose of ERISA was to *protect* beneficiaries, will this 'new dispensation' by judicial construction, take away all of the effective traditional remedies of the beneficiaries?") (original emphasis); Note, "Blind Faith Conquers Bad Faith" 21 Loy. L.A. Law Review 1343, 1347 (1988) (without tort liability, insurers have nothing to lose by withholding payments; preemption effectively removes incentive from insurers to deal fairly with beneficiaries); Gregory, "The Scope of ERISA Preemption of State Law: A Study of Effective Federalism," 48 U. Pitt. Law Rev. 427, 457 (1987) ("If ERISA preempted all state law relating to employee benefit plans, a dangerous vacuum would result").

The effect of ERISA's preemptive force is magnified to an even greater extent in light of the lack of other means of redress. For example, this Court's recent decision in *Mertens v. Hewitt Assocs.*, ___ U.S. ___, 124 L.Ed.2d 161, 113 S.Ct. 2-73 (1993), definitively holds that one harmed by the actions of an ERISA fiduciary is not entitled to damages, as "other equitable relief," pursuant to § 502(a) of ERISA, 29 U.S.C. § 1132(a). The Eighth Circuit Panel, almost apologetically, confirmed that the *Mertens* decision, along with the sweeping language which the courts have applied to the preemption doctrine, have created a gaping hole in the statutory remedies available to the individuals who were intended to be afforded the broadest protection under ERISA.

Pursuant to the courts' sweeping construction of the preemption doctrine, and with the advent of prospective

medical decision-making by the HMOs and the recent *Mertens* decision, ERISA has literally been converted into nothing more than an incentive for HMOs to avoid, delay or preclude the rendering of costly medical procedures to the patient/member. Without threat of legal recourse, an HMO's most cost-effective decision-making process includes the provision of only suboptimal medical care to the patient/member or the gross reality of simply allowing the patient/member to die. It no longer makes economic sense for the HMO to base its medical decision-making on the best interests of patient/members. Buddy Kuhl was a victim of that kind of dollar-driven, medical decision-making by Lincoln National, and he died as a result.

The decisions of the District and Eighth Circuit Courts, herein, provide an incentive for medical professionals, acting on behalf of HMOs, to "take over" the medical treatment of the patient/member and to simultaneously disregard the advice and recommendations of the patient/member's treating physicians and specialists. With the protective shield of ERISA, as defined by the courts below, there is nothing to protect the patient/member from the wrongful acts of the HMO health care providers. As here, the wrongful and deliberate acts of the HMO agents may very well result in the death of the patient/member but, under the Eighth Circuit's perception of the law, the patient/member or his beneficiaries have no legal recourse. It is clear that this was not Congress' intent or purpose in enacting ERISA.

c. This Court Has Authority to Protect the Goals Espoused in Creating ERISA

In its adoption, Congress clearly realized that the ERISA statute would not address every issue. With this in mind, Congress empowered federal courts with the authority "to develop a body of federal common law that govern issues in ERISA actions not covered by the act itself." *Psychiatric Institute v. Connecticut General*, 780 F. Supp. 24, 32 (D.D.C. 1992); *Kane v. Aetna Life Ins. Co.*, 893 F.2d 1283, 1285 (11th Cir.), *cert. denied*, ___ U.S. ___, 111 S.Ct. 232, 112 L.Ed.2d 192 (1990); *Foltz v. U.S. News & World Report, Inc.*, 627 F. Supp. 1143, 1176 (D.D.C. 1986). "Congress intended that the court use this authority to develop a body of federal substantive law to deal with issues involving rights and obligations under private welfare and pension plans." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11, 109 S.Ct. 948, 954, 103 L.Ed.2d 80 (1989).

One issue which Congress perhaps could not have predicted when drafting ERISA was the interjection of the medical utilization review process into the system. *See Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1334 (5th Cir.), *cert. denied*, ___ U.S. ___, 121 L.Ed.2d 684, 113 S.Ct. 812 (1992). The newly developing HMO practice was not one which should realistically have been addressed by Congress when drafting the ERISA statute. Today, however, with the every-expanding use of employer-sponsored HMO benefit plans, this Court must have the courage to formulate law which is necessary to properly promote the employees' interests. Relying upon the congressionally-delegated authority granted this

Court, and looking to the realities of present day HMO practices, this court can ensure the rights owed to individuals, such as Buddy Kuhl and his family, and can enforce the obligations of HMO medical personnel so that they may be held accountable for tortious acts occurring when they take actions which go beyond the mere administration of benefits and undertake the medical care of individuals, such as Buddy Kuhl.

D. There is Confusion Among the Circuit Courts on the Issue of Preemption of Emotional Distress Claims

The decisions of the Circuits are split on the issue of whether or not a claim for emotional distress is preempted by ERISA. *See, e.g., Drinkwater, infra; Johnson v. District 2 Marine Eng'rs Beneficial Ass'n,* 857 F.2d 514 (9th Cir. 1988); *Powell v. Chesapeake and Potomac Telephone Co.,* 780 F.2d 419 (4th Cir. 1985), *cert. denied,* 476 U.S. 1170 (1986). The Eighth Circuit and District Court, in rendering their decisions, erroneously chose to follow the principles of the latter two cases. Plaintiffs contend, however, that the former is more applicable to the facts herein and seek this Court's guidance in rectifying the division among this nation's Circuit Courts.

In *Drinkwater v. Metropolitan Life Insurance Company,* 846 F.2d 821, 825 (1st Cir.) *cert. denied,* 488 U.S. 909, 109 S.Ct. 261, 102 L.Ed.2d 249 (1988), the First Circuit held that a wife's claim for emotional distress was not preempted by ERISA, even though the injury was suffered as a result of a denial of benefits to her husband under an employee welfare benefit plan. In *Drinkwater,* the plan's

refusal to pay benefits was alleged to have contributed to the plaintiff's spouse's death. The *Drinkwater* court held this claim was too tangentially affected by ERISA to warrant preemption.

In the instant case, plaintiffs' claims are even more tangentially related to ERISA than the *Drinkwater* claim. Specifically, the emotional distress suffered by plaintiff Mary Kuhl herein does not flow from a denial of justified benefits under the plan, but rather arises from the cancellation of scheduled life-saving surgery by the HMO and its negligent undertaking of Buddy Kuhl's medical care, and the HMO's intentional interference in the provision of appropriate health care to Buddy Kuhl by the physicians with whom he had contracted. The plaintiff herein should clearly not suffer preemption under these circumstances, and this Court should grant the petition to resolve the conflict among the Circuits on this issue and clarify the law for the lower courts.

E. In Considering the Defendant's Motion for Summary Judgment, the Courts Below Failed to Accept as True the Evidence Averred by Plaintiffs and to View All Inferences in the Light Most Favorable to Them

This Court should grant the Kuhls' writ because the District Court and Eighth Circuit decisions are inconsistent with this Court's previous decisions regarding the appropriate standard and presumptions employed in deciding a motion for summary judgment. That is, in considering a motion for summary judgment, all inferences drawn by the court are to be viewed in the light

most favorable to the party opposing the motion. *United States v. Diebold*, 369 U.S. 654, 655 (1962). Moreover, the evidence of the party opposing the motion "is to be believed" and that party's "version of any disputed issue of fact . . . is presumed correct." *Eastman Kodak Co. v. Image Technical Services*, ___ U.S. ___, 119 L.Ed.2d 265, 277, 112 S.Ct. 2072 (1992) (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986); *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 339 (1982)). *See also, Lujan v. National Wildlife Federation*, 497 U.S. 871, 888 (1990) ("where the facts specifically averred by [the non-moving party] contradict facts specifically averred by the movant, the motion must be denied").

The Eighth Circuit, in rendering its opinion in the instant case, repeated the maxim that it was to consider the facts in the light most favorable to the Kuhls. *Kuhl*, 999 F.2d at 303. However, in support of the court's primary basis for affirming the District Court's decision to grant summary judgment, the Eighth Circuit then flatly rejected the facts averred by the Kuhls, including the sworn, uncontested testimony of Buddy Kuhl's heart specialist, Dr. Bernard Levi. Dr. Levi, (a participating provider under an agreement with Lincoln National), provided an affidavit in support of the plaintiffs' Motion to Remand and in response to defendant's Motion for Summary Judgment, in which he testified:

> Notwithstanding the fact that Buddy Kuhl was my patient and notwithstanding . . . [my] . . . contractual provisions with Lincoln National, and in direct contravention of my advice to Lincoln National and to my patient,

> Buddy Kuhl, Lincoln National, in effect, canceled the surgery which had been scheduled at Barnes Hospital and sent Buddy Kuhl, against my direct recommendation, to Dr. Brodine at Research Hospital. *In so doing, Lincoln National, through its actors, assumed medical care of Buddy Kuhl.*

(emphasis added).[6]

The Kuhls also provided the District Court and Eighth Circuit Panel evidence of the manner in which Lincoln National returned Buddy Kuhl to Dr. Levi's care, after having assumed that care itself. Dr. Levi's uncontested testimony provided:

> I later learned that Dr. Brodine agreed with my recommendation and . . . Lincoln National notified me that they were following Dr. Brodine's recommendations and would authorize surgery in St. Louis as I had earlier recommended and arranged. [Lincoln National's] letter stated that Mr. Kuhl was to arrange the surgery through me. The letter also said that after the surgery "all hospital care must be rendered by Dr. Levi." Thus, *after assuming care of Buddy Kuhl and taking Buddy Kuhl from my care on June 23, 1989, Lincoln National returned Buddy Kuhl to my care on July 20, 1989.*

(emphasis added).

---

[6] As indicated by Dr. Levi, the decision made by the HMO to cancel the surgery at Barnes Hospital was directly contrary to the medical advice provided by him to the agents of the HMO. Dr. Levi had informed the HMO that the alternative site for the surgery, contemplated by the HMO, was unacceptable because its surgeons were "incompetent and inadequate," and that Buddy's chances of survival, outside of Barnes, were "suboptimal" and "dismal."

Thus, the evidence submitted by the plaintiffs on this material issue of fact clearly illustrates that, despite overwhelming medical advice provided to the HMO, the doctor and nurses at Lincoln National made their own medical determination regarding the propriety of care to be provided to Buddy Kuhl, the significance of the timing of that care and the location at which the care would be rendered. The doctor and nurses at the HMO canceled the surgery at Barnes Hospital, established the appointment for Buddy Kuhl to see yet another physician (set mutually exclusive of the surgery at Barnes) and informed Buddy Kuhl that he was to proceed with their assessment of appropriate health care. In short, the HMO undertook the medical care of Buddy Kuhl.

Directly contrary to the evidence submitted by non-movant Kuhls, the Eighth Circuit found that "Lincoln National's admission that it 'canceled' the surgery cannot be stretched to imply that Lincoln National went beyond the administration of benefits and undertook to provide Buddy Kuhl with medical advice." *Kuhl*, 999 F.2d at 303. In reaching this conclusion, inconsistent with and directly contrary to the Kuhls' uncontroverted evidence (and all inferences to be drawn therefrom), the District Court and Eighth Circuit have apparently sought to promote judicial efficiency, all at the expense of justice and the express dictates of this Court. The extreme remedy of summary judgment is not appropriate, in a case such as this, where the moving party can purportedly establish its right to judgment only because the court erroneously fails to presume that the evidence of the non-moving party is true and looks, instead, upon the evidence in a manner favorable to the moving party. *See, Anderson v. Liberty Lobby,*

Inc., supra; Inland Oil & Transp. Co. v. United States, 600 F.2d 725, 727 (8th Cir.), *cert. denied*, 444 U.S. 991, 100 S.Ct. 522, 62 L.Ed.2d 420 (1979); *U.S. v. Feinstein*, 717 F. Supp. 1552, 1555 (S.D. Fla. 1989).

VIII. CONCLUSION

For the foregoing reasons, the Petitioners Mary Kuhl, Buddy Kuhl, Jr. and Marnie K. Kuhl respectfully request that their petition for a Writ of Certiorari be granted.

Respectfully submitted,

JOHN S. BLACK,
Counsel of Record
C. W. CRUMPECKER, JR.
LINDA J. SALFRANK
JAMES A. DURBIN
SWANSON, MIDGLEY, GANGWERE,
CLARKE & KITCHIN
922 Walnut, Suite 1500
Commerce Trust Building
Kansas City, MO 64106
(816) 842-6100 (Telephone)
(816) 842-0013 (Telefax)

Attorneys for Petitioners
Mary Kuhl, Buddy Kuhl, Jr. and
Marnie K. Kuhl

United States Court of Appeals
FOR THE EIGHTH CIRCUIT

Nos. 92-2604/92-2607

Mary Kuhl; Buddy Kuhl, Jr.; Marnie K. Kuhl, Appellants, v. Lincoln National Health Plan of Kansas City, Inc., Appellee.	* * * * * * * * * *	Appeal from the United States District Court for the Western District of Missouri.

Submitted: January 14, 1993

Filed: July 7, 1993

Before WOLLMAN and BEAM, Circuit Judges, and BOGUE,* Senior District Judge.

BEAM, Circuit Judge.

This consolidated appeal arises from the district court's[1] orders resolving two actions brought against Lincoln

---

* The HONORABLE ANDREW W. BOGUE, Senior United States District Judge for the District of South Dakota, sitting by designation.

[1] The Honorable D. Brook Bartlett, United States District Judge for the Western District of Missouri.

National Health Plan of Kansas City, Inc. (Lincoln National) as a result of the death of its insured, Buddy Kuhl. The district court held that the plaintiffs' state law claims against Lincoln National were preempted by the Employee Retirement Income security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461, and that ERISA did not authorize the recovery of monetary damages for Lincoln National's alleged misconduct. We affirm both orders of the district court.

I. BACKGROUND

Lincoln National is an "independent physician" HMO, which means that it pays independent physicians, hospitals, and other health care providers to render medical services for its members. Pursuant to a contract between Lincoln National and Belger Cartage Services, Inc. (Belger), Lincoln National pays for medical services provided to Belger employees under Belger's Group Health Plan. Belger's Group Health Plan is an "employee welfare benefit plan" regulated under ERISA. 29 U.S.C. § 1002(1). Under the Belger Plan, Lincoln National is not contractually obligated to pay for medical services rendered outside the "Service Area" of the Lincoln National network or for medical services rendered by personnel not participating in the Lincoln National network. All decisions concerning the payment of claims under the Belger Plan are the responsibility of Lincoln National. Lincoln National makes advance decisions regarding payment for medical services rendered outside of its service area through "precertification review," a process by which it determines whether a particular procedure or hospitalization is covered by the Belger Plan.

Buddy Kuhl was an employee of Belger, and had opted to receive medical benefits under the Belger Plan administered by Lincoln National as of March 1, 1989. On April 29, 1989, Buddy Kuhl suffered a heart attack. Dr. Grimes, Buddy Kuhl's designated primary care physician, placed Buddy Kuhl in the care of Dr. Levi, a heart specialist at Menorah Medical Center. Dr. Levi concluded that heart surgery was necessary, including open heart LV aneurysmectomy and a coronary by-pass. Lincoln National arranged for a second opinion by Dr. Ahuja. In a letter dated May 23, 1989, Dr. Ahuja confirmed that surgery was necessary, stating that Buddy Kuhl was "at high risk of sudden death" and needed the recommended surgery "in the next few weeks." App. 300-01.

Buddy Kuhl underwent extensive tests at Menorah between June 13, 1989, and June 16, 1989, to determine the extent of his heart damage and the proper course of treatment. On June 20, 1989, Dr. Levi determined that Buddy Kuhl had inducible ventricular tachycardia and would need formal electrophysiologically guided left ventricular aneurysm resection and subendocardial resection, as well as his bypass surgery. Because the Kansas City area hospitals did not have the equipment to perform the necessary surgery, Dr. Levi concluded that Buddy Kuhl would have the best chance of survival if the surgery were performed at Barnes Hospital in St. Louis, Missouri. Dr. Levi also noted that the surgeons at Barnes Hospital had more experience and success with this type of surgery than any doctor in Kansas City. Dr. Hannah, a cardiac surgeon at Menorah and a participating provider under the Belger Plan, concurred in Dr. Levi's conclusions. Therefore, arrangements were made for Dr. Cox, a

heart surgeon specializing in computerized cardiac mapping and bypass surgery, to perform the surgery at Barnes Hospital on July 6, 1989.

On June 20, 1989, Dianne Long, a utilization review coordinator for Lincoln National, received a call from Barnes Hospital requesting precertification for the surgery. On June 23, 1989, Lincoln National refused to precertify payment for the surgery because Barnes Hospital is outside the Lincoln National service area. The surgery scheduled for July 6, 1989, was cancelled. Lincoln National then scheduled an appointment for Buddy Kuhl to see Dr. Brodine at Research Medical Center in Kansas City on July 6, 1989, to determine whether the surgery could be performed in Kansas City rather than in St. Louis. After examining Buddy Kuhl, Dr. Brodine immediately informed Lincoln National that he agreed with the recommendations of Dr. Levi and Dr. Hannah that the surgery should be performed at Barnes Hospital.

Two weeks later, on July 20, 1989, Lincoln National informed Buddy Kuhl that it would authorize the surgery at Barnes Hospital. Buddy Kuhl immediately attempted to schedule the surgery, but was informed that the surgery team was unavailable until September 1989. On September 2, 1989, Dr. Cox examined Buddy Kuhl in anticipation of surgery and found that his heart had deteriorated to such an extent that the proposed surgery was no longer a viable option. Dr. Cox recommended that Buddy Kuhl be evaluated for cardiac transplantation and asked that he be placed on a heart transplant waiting list at Barnes Hospital. Lincoln National refused to precertify payment of these medical costs. However, Buddy Kuhl

was placed on a heart transplant waiting list at Kansas University Medical Center.

Buddy Kuhl died as a result of ventricular tachycardia on December 28, 1989, while waiting for a heart transplant.

On March 15, 1991, Mary Kuhl, Buddy Kuhl, Jr., and Marnie K. Kuhl (the Kuhls) filed a petition in the Circuit Court of Jackson County, Missouri, asserting four claims against Lincoln National: medical malpractice, emotional distress, tortious interference with Buddy Kuhl's right to contract for medical care, and breach of a contract through Buddy Kuhl as a third-party beneficiary. Lincoln National filed a Notice of Removal pursuant to 28 U.S.C. § 1441(b), asserting that ERISA provides federal question jurisdiction over each of the Kuhls' claims. The Kuhls sought remand, arguing that ERISA did not apply. Lincoln National opposed the motion to remand and filed a motion for summary judgment on the grounds of ERISA preemption. The district court determined that the Kuhls' state law claims arise from the administration of the Belger Plan and therefore are preempted as claims that "relate to" an ERISA plan. The court also examined the possible remedies under ERISA, and concluded that the Kuhls could not state a claim under ERISA. Accordingly, the district court denied the Kuhls' motion to remand and granted summary judgment in favor of Lincoln National.

The Kuhls then moved to amend the judgment, moved to amend their complaint to include a cause of action under ERISA, and filed a second suit in the district court alleging that Lincoln National breached its fiduciary duty under ERISA. Lincoln National opposed the

Kuhls' motions and filed a motion to dismiss the second complaint. The district court denied the Kuhls' motion to amend the original complaint because the action had been dismissed and the Kuhls' proffered no reason why the amendments were not made before the action was dismissed. Additionally, the court concluded that the Kuhls' state law claims could not be recharacterized as ERISA claims and thus, reaffirmed its grant of summary judgment in favor of Lincoln National. Finally, the court granted Lincoln National's motion to dismiss the second complaint on three grounds: (1) the court's grant of summary judgment in favor of Lincoln National was res judicata as to the allegations in the second complaint; (2) under the reasoning in the court's order granting summary judgment, the Kuhls could not state a cause of action under ERISA for breach of a fiduciary duty; and (3) the "other equitable relief" clause in 29 U.S.C. § 1132(a)(3)(B)(i) does not include monetary damages.

On appeal, the Kuhls argue that the district court erred in granting Lincoln National's motion for summary judgment and in denying the Kuhls' motion to remand because their state law claims are not preempted by ERISA. In the alternative, the Kuhls contend that the district court erred in not recharacterizing their state law claims under ERISA, in denying their motion to amend the original complaint to include a cause of action under ERISA, and in dismissing their second complaint.

II. DISCUSSION

A. ERISA Preemption

ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries by

regulating the creation and administration of employee benefit plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987). "The statute imposes participation, funding, and vesting requirements on pension plans. It also sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for both pension and welfare plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) (citations omitted). Consistent with the decision to create a comprehensive, uniform federal scheme for regulation of employee benefit plans, Congress drafted ERISA's preemption clause in broad terms. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990).

Under section 514(a) of ERISA, as set forth in 29 U.S.C. § 1144(a), Congress preempted "all State laws insofar as they may now or hereafter relate to any employee benefit plan."[2] Statutory mandates, court decisions, and state law from all other sources are included in the preemption clause. 29 U.S.C. § 1144(c)(1). The question of whether a certain state law is preempted by ERISA is necessarily a question of legislative intent, and the Supreme Court has left no doubt that Congress intended

---

[2] The full text provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a). Section 514(b) exempts certain state laws from preemption, but none of these exemptions is applicable here.

the preemption clause to be construed extremely broadly. *See Ingersoll-Rand*, 498 U.S. at 138 ("[i]ts deliberately expansive language was designed to establish pension plan regulation as exclusively a federal concern") (quotation omitted); *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) ("[t]he preemption clause is conspicuous for its breadth").

The key to determining whether a state law is preempted is whether the state law in question "relates to" an ERISA plan. 29 U.S.C. § 1144(a). "A law [clearly] 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw*, 463 U.S. at 96-97. Moreover, ERISA's preemption clause is not limited to laws which relate to the specific provisions of ERISA. A state law may "relate to" an employee benefit plan, and therefore be preempted, even though the state law was not designed to affect benefit plans and its effect on such plans is only incidental. *Ingersoll-Rand*, 498 U.S. at 139.

Despite Congress' intention that ERISA cut a wide swath of preemption through state laws, the Supreme Court has recognized that not every cause of action that might be brought against an ERISA plan is preempted. "Some state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. In *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988), the Court held that ERISA did not preempt a state's general garnishment statute as applied to collect judgments against plan participants. The Court noted that although collection might burden

the administration of the plan, this fact was not dispositive on the question of whether the state law "relates to" the benefit plan. *Id.* at 841. Thus, the court's decisions do not provide a clear-cut method for determining whether a state law which merely has some unintended effects on ERISA-governed plans will be preempted.

1. Tortious Interference, Medical Malpractice, and Breach of Contract

We have no difficulty in concluding that the Kuhls' three state law claims that rely on Buddy Kuhl's status as a beneficiary of the Belger Plan are preempted by ERISA. The Kuhls' claims are all based on Lincoln National's alleged misconduct in delaying Buddy Kuhl's heart surgery in St. Louis. The Kuhls contend that Lincoln National tortiously interfered with the contractual relationship between Buddy Kuhl and his doctors, that Lincoln National committed medical malpractice because it assumed the role of Buddy Kuhl's physician by making decisions about proper medical treatment and made decisions that constitute medical malpractice, and that Lincoln National breached its contract with Belger, to which Buddy Kuhl was a third-party beneficiary, by delaying the surgery in St. Louis. The district court found that all of these state law claims arise from the administration of benefits under the Belger Plan and are therefore preempted by ERISA. We agree.

In *Pilot Life*, the Supreme Court held that ERISA preempts state common-law causes of action arising from the alleged improper processing of a claim for benefits under an ERISA-regulated plan. 481 U.S. at 57. In that

case, the beneficiary of an ERISA-regulated plan brought state common law tort and contract claims against the insurer for failure to pay benefits under the insurance policy. The Court held that these state law claims "relate to" the employee benefit plan and thus, the comprehensive civil enforcement scheme detailed in the provisions of section 502(a) of ERISA provides the exclusive remedies for claims involving the administration of plan benefits. "The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.* at 54.

The Kuhls attempt to avoid ERISA preemption by suggesting that Lincoln National's actions with respect to Buddy Kuhl went beyond the mere administration of benefits. They assert that Lincoln National not only refused to precertify payment for Buddy Kuhl's operation, but "cancelled" the operation and undertook treatment of Buddy Kuhl according to its own medical opinions. The Kuhls rely heavily on Lincoln National's admission for the purpose of its motion for summary judgment that it "cancelled" the surgery scheduled for July 6, 1989, in St. Louis. *See* App. at 154 n.1. The district court rejected the Kuhls' arguments, concluding that the Kuhls' "claims are based on the manner in which Lincoln National responded to the request for 'pre-certification' of Buddy Kuhl's heart surgery. Artful pleading by characterizing Lincoln National's actions in refusing to pay for the surgery as 'cancellation' or by characterizing the same administrative decisions as 'malpractice' does not change

the fact that plaintiffs' claims are based on the contention that Lincoln National improperly processed Kuhl's claim for medical benefits." *Kuhl v. Lincoln National Health Plan of Kansas City, Inc.*, No. 91-0330-CV-W-9, order at 17 (W.D. Mo. Dec. 26, 1991).

Taking the facts in the light most favorable to the Kuhls, as we must for purposes of Lincoln National's motion for summary judgment, we are compelled to agree with the district court. Lincoln National became involved in the cancellation of the St. Louis surgery only after the Barnes Hospital staff requested a precertification review. Lincoln National's admission that it "cancelled" the surgery cannot be stretched to imply that Lincoln National went beyond the administration of benefits and undertook to provide Buddy Kuhl with medical advice. Although the surgery in St. Louis was unquestionably cancelled as a result of Lincoln National's decision not to precertify payment, the decision not to precertify payment relates directly to Lincoln National's administration of benefits.

We do not imply that how the surgery was cancelled would be immaterial in every case. In a different case, the cancellation of a beneficiary's surgery by an ERISA benefits provider may lay the basis for non-preempted state law claims. Here, however, the Kuhls have failed to allege that there was a practical difference between Lincoln National "cancelling" the surgery and simply denying precertification. The Kuhls make no allegations that Buddy Kuhl would have had the surgery even if Lincoln National refused to pay for it; that Buddy Kuhl was thwarted in his efforts to arrange other financing for the surgery upon Lincoln National's "cancellation;" or that

the timing of the "cancellation" made it impossible for Buddy Kuhl to have the surgery on July 6, 1989, if payment could be otherwise arranged.[3] The July 18, 1989, letter that Buddy Kuhl wrote to Dr. Grimes requesting her assistance in persuading Lincoln National to certify payment for his surgery makes it clear that he was not under the misconception that Lincoln National had taken the place of his treating physicians. *See* App. at 258.

Under *Pilot Life*, any state law claim that Buddy Kuhl may have had against Lincoln National for its conduct in delaying the surgery scheduled for July 6, 1989, arose from Lincoln National's denial of benefits under the Belger Plan. The Kuhls' attempt to invoke *Mackey* and to characterize their claims as merely tangentially related to the Plan is unpersuasive. Accordingly, the Kuhls' state law claims through Buddy Kuhl "relate to" the Belger plan and are preempted by ERISA.

2. Emotional Distress

Mary Kuhl, Buddy Kuhl's wife, also asserts a claim for intentional infliction of emotional distress, alleging that she was aware that Lincoln National "cancelled" Buddy Kuhl's surgery; that she was present when he was informed in September 1989 that his heart could no longer withstand surgery and transplantation was his only remaining option; and that she was present when

---

[3] The Kuhls allege that Lincoln National "cancelled" Buddy Kuhl's surgery on June 23, 1989, and did not inform him until June 27, 1989. However, they do not allege that this delay altered Buddy Kuhl's response to the "cancellation" in any way.

Buddy Kuhl collapsed and died while waiting for a heart to become available. Mary Kuhl relies on dicta in *Drinkwater v. Metro. Life Ins. Co.*, 846 F.2d 821, 826 (1st Cir.), *cert. denied*, 488 U.S. 909 (1988) for the proposition that claims for emotional distress are not preempted by ERISA. She attempts to distinguish the persuasive precedent to the contrary, *see, e.g., Johnson v. District 2 Marine Eng'rs Beneficial Ass'n*, 857 F.2d 514, 517-18 (9th Cir. 1988) *and Powell v. Chesapeake and Potomac Telephone Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986), on the grounds that her underlying vicarious malpractice claim is not preempted by ERISA. *See* Kuhls' Reply Brief at 12.

As we previously indicated, Mary Kuhl is mistaken in her contention that her underlying state law claim for medical malpractice is not preempted. Mary Kuhl's claim for emotional distress, like the Kuhls' other state law claims, is based upon Lincoln National's failure to expeditiously precertify payment for the St. Louis surgery. We conclude that Mary Kuhl's claim for emotional distress "relates to" Lincoln National's administration of the Belger Plan within the broad meaning of the ERISA preemption clause. Accordingly, Mary Kuhl's claim for emotional distress is also preempted under section 514(a) of ERISA.

We recognize the obvious salutary effect that imposing state law liability on Lincoln National might have on deterring poor precertification decisions. However, this is precisely the type of state regulation of plan administration that ERISA was designed to replace. "Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial

burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand*, 498 U.S. at 142. Other courts have speculated that Congress could not have foreseen the precertification review process when it enacted a preemption clause so broad that it relieves ERISA-regulated plans of most tort liability. *See Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1334 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992). Although this may well be true, modification of ERISA in light of questionable modern insurance practices must be the job of Congress, not the courts.

B. ERISA Claims

The Kuhls' [sic] argue that even if their state law claims are preempted by ERISA, the district court erred by not recharacterizing their state law claims under ERISA, by denying the Kuhls' motion to amend the complaint to allege a cause of action under ERISA, and by dismissing their subsequent complaint alleging a breach of fiduciary duty under ERISA. Although the Kuhls apparently did not ask the district court to recharacterize their state law claims under ERISA, *see* App. at 830-31, the court examined the civil remedies available under section 502(a) of ERISA, 29 U.S.C. § 1132(a), and concluded that the Kuhls' factual allegations do not state a claim under ERISA. The Kuhls suggest that section 502(a)(3)(B)(i), 29 U.S.C. § 1132(a)(3)(B)(i), permits them to recover monetary damages for Lincoln National's

alleged breach of its fiduciary duty.[4] They argue that we should follow the Sixth Circuit's determination that monetary damages constitute "other appropriate equitable relief." *See Warren v. Society Nat'l Bank*, 905 F.2d 975, 982 (6th Cir. 1990), *cert. denied*, 111 S. Ct. 2256 (1991).

We have previously held that monetary damages are not available under section 502(a)(3)(B)(i). *Novak v. Andersen Corp.*, 962 F.2d 757, 759 (8th Cir. 1992), *cert. denied*, 61 U.S.L.W. 3818 (1993). In *Novak*, we expressly rejected the *Warren* court's reasoning and held that an award of monetary damages is a legal remedy, not an equitable one. *Id.* at 761. This interpretation has recently been vindicated by the Supreme Court. *Mertens v. Hewitt Assocs.*, 61 U.S.L.W. 4510, (June 1, 1993). After an extensive review of the history of equitable remedies and the statutory language of section 502(a)(3), the Court concluded that damages do not constitute "other equitable relief." *Id.* at 4512-14. The district court properly held that the Kuhls' claim for monetary damages was not cognizable under section 502(a)(3)(B)(i).[5]

---

[4] Section 502(a) provides:

A civil action may be brought –

. . . .

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any Provisions of this subchapter or the terms of the plan.

[5] Our resolution of the claim for monetary damages makes it unnecessary for us to review the district court's other rationales for denying the Kuhls relief under ERISA. We note, however, that it is far from clear that the Kuhls could state a cause of

III. CONCLUSION

For the reasons discussed above, the orders of the district court are affirmed.

A true copy.

Attest:

CLERK, U. S. COURT OF APPEALS, EIGHTH CIRCUIT.

---

action for a breach of fiduciary duty under 29 U.S.C. § 1104(a)(1) that would allow a remedy for certain injured individuals, rather than the Plan as a whole.

UNITED STATES COURT OF APPEALS

For The Eighth Circuit

No. 92-2604WMKC
No. 92-2607WMKC

Mary Kuhl; Buddy Kuhl, Jr.; Marnie K. Kuhl,	*	
Appellants,	*	Order Denying Petition for Rehearing and Suggestion for Rehearing En Banc
vs.	*	
Lincoln National Health Plan of Kansas City, Inc.,	*	
Appellee.	*	

The suggestion for rehearing en banc is denied. The petition for rehearing is also denied.

August 13, 1993

Order Entered at the Direction of the Court:

/s/ Michael E. Gans

Clerk, U.S. Court of Appeals, Eighth Circuit

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

MARY KUHL, et al,	)	
Plaintiffs,	)	
	)	
v.	)	No.
LINCOLN NATIONAL HEALTH PLAN OF KANSAS CITY, INC.,	)	91-0330-CV-W-9
Defendant.	)	
	)	

ORDER DENYING PLAINTIFFS' MOTION TO REMAND AND GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

(Filed Dec. 26, 1991)

I. Introduction

On March 15, 1991, plaintiffs Mary Kuhl, Buddy Kuhl, Jr. and Marnie K. Kuhl filed their Petition in the Circuit Court of Jackson County, Missouri, asserting four claims against defendant Lincoln National Health Plan of Kansas City, Inc. (Lincoln National): medical malpractice, emotional distress, tortious interference with decedent Buddy L. Kuhl, Sr.'s right to contract for medical care and breach of a contract of which Buddy Kuhl Sr. was a third-party beneficiary.

On April 11, 1991, defendant filed its Notice of Removal pursuant to 28 U.S.C. § 1441(b), stating that federal question jurisdiction exists over plaintiffs' claims because the Employee Retirement Income Security Act of

1974 (ERISA), 29 U.S.C. § 1001, *et seq.*, preempts each claim.

On May 14, 1991, plaintiffs moved to remand this case to the Circuit Court of Jackson County, Missouri, because no federal question appears on the face of the Complaint and the case is not otherwise removable based on the "complete preemption doctrine."

On June 10, 1991, defendant moved for summary judgment arguing that plaintiffs' claims are preempted by ERISA.

II. Facts

Lincoln National Health Plan is a health insurance organization which contracted with Belger Cartage Services, Inc. (Belger) to administer a Group Medical Plan provided by Belger to its employees. Because Lincoln National Health Plan is an "independent physician" HMO, it does not have doctors or nurses on staff who render medical services. Instead, it pays independent physicians, hospitals and other health care providers for rendering medical services to members.

Pursuant to the contract between Lincoln National Health Plan and Belger, Lincoln National pays for medical services provided to Belger employees according to the restrictions, limitations and exclusions set forth in the contract. Lincoln National is not obligated to automatically pay for medical services rendered outside the "Service Area" of the Lincoln National network or for medical services rendered by doctors not participating in the Lincoln National network. All decisions concerning payment

of claims or benefits under the Plan were the responsibility of Lincoln National.

Lincoln National conducts a "pre-certification" review of hospital admissions. In the pre-certification review, Lincoln National determines whether a particular procedure or hospitalization is covered by the Plan.

The Belger Group Medical Plan is an "employee benefit plan" and an "employee welfare benefit plan" within the meaning of ERISA.

Buddy Kuhl was an employee of Belger. As of March 1, 1989, Buddy Kuhl had opted to receive medical benefits under the Plan administered by Lincoln National.

On April 29, 1989, Buddy Kuhl suffered a heart attack. With the approval of Dr. Virginia Grimes, Buddy Kuhl's designated primary care physician, Buddy Kuhl was placed in the care of Dr. Bernard Levi, a heart specialist at Menorah Medical Center. Dr. Levi concluded that heart surgery would be necessary, including open heart LV aneurysmectomy and coronary by-pass surgery. This recommendation was confirmed by Dr. Ahuja in a May 23, 1989, letter stating that Buddy Kuhl was a "candidate for sudden death" and needed the recommended surgery "in the next few weeks."[1] Lincoln National received a copy of this second opinion.

On June 8, 1989, Dr. Levi wrote a letter to Dr. Grimes informing her that Buddy Kuhl would be readmitted to Menorah for observation and electrophysiological testing on June 15, 1989, to determine whether Buddy Kuhl had

---

[1] Lincoln National arranged for the second opinion rendered by Dr. Ahuja.

inducible ventricular tachycardia. Dr. Levi stated that if he determined that Buddy Kuhl suffered from that condition, he would strongly recommend consultation with Dr. James Cox of Barnes Hospital in St. Louis for formal electrophysiological guided left ventricular aneurysm resection and subendocardial resection as well as bypass surgery.

Between June 13, 1989, and June 16, 1989, Buddy Kuhl underwent extensive tests at Menorah to determine the extent of the heart damage and to determine the proper course of treatment. Dr. Levi instructed Buddy Kuhl that the best course was to have bypass surgery and an aneurysm removal. On June 20, 1989, Dr. Levi determined that Buddy Kuhl would have the best chance of survival if the surgery were performed at Barnes Hospital in St. Louis, Missouri. Dr. Levi concluded that Kansas City area hospitals did not have the equipment to perform the technically advanced computerized surgery and the surgeons at Barnes were more experienced and successful than any doctor in Kansas City. Therefore, arrangements were made for Dr. Cox, a heart surgeon specializing in computerized cardiac mapping and bypass surgery on patients with ventricular tachycardia, to perform the surgery at Barnes Hospital on July 6, 1989. Dr. Hannah, a cardiac surgeon at Menorah and a participating provider under the Plan, agreed with Dr. Levi's determination that Buddy Kuhl's best interests would be served by having Dr. Cox perform the surgery at Barnes.

On June 20, 1989, Dianne Long, a utilization review coordinator for Lincoln National, received a telephone call from Barnes Hospital. Barnes Hospital informed Long that surgery had been scheduled for July 6, 1989,

and requested pre-certification review. On June 23, 1989, Lincoln National refused to certify benefits for the surgery because Barnes Hospital was outside the Lincoln National "Service Area." The surgery was cancelled.

Lincoln National scheduled a July 6, 1989, appointment for Buddy Kuhl to see Dr. Brodine at Research Medical Center in Kansas City to determine whether the surgery could successfully be performed in Kansas City rather than in St. Louis. Dr. Brodine concurred with Dr. Levi's recommendation that the heart surgery should be performed by Dr. Cox in St. Louis due to the availability of technically advanced computerized cardiac mapping facilities at Barnes Hospital. Dr. Brodine informed Dianne Long of his opinion on July 6, 1989.

On July 20, 1989, Lincoln National informed Buddy Kuhl that it would authorize the surgery at Barnes Hospital. Buddy Kuhl immediately contacted Barnes Hospital to reschedule the surgery. He was informed that the surgery could not be performed until September 1989, due to the unavailability of the surgical team.

Buddy and Mary Kuhl traveled to St. Louis on September 2, 1989, in anticipation of surgery. However, based on tests conducted prior to the surgery, Dr. Cox found that Buddy Kuhl's heart had deteriorated to such an extent that "[he] no longer felt [Buddy Kuhl] was a reasonable operative candidate." Dr. Cox recommended that Buddy Kuhl be evaluated for cardiac transplantation "because that [was] really the only thing left to offer."

The physicians at Barnes asked that additional testing be conducted and that Buddy Kuhl be placed on a heart transplant waiting list at Barnes Hospital. Lincoln

National refused to pre-certify payment of these medical costs. However, Buddy Kuhl was placed on a heart transplant waiting list at Kansas University Medical Center.

While waiting for a heart transplant, Buddy Kuhl died due to ventricular tachycardia on December 28, 1989.

II. Applicable Standards

A. Standard for Remand

Title 28 U.S.C. § 1447(c), Federal Rules of Civil Procedure, which governs motions to remand, provides:

> A motion to remand the case on the basis of any defect in removal procedure must be made within 30 days after the filing of the notice of removal under section 1446(a). *If at any time before final judgment it appears that the district court lacks subject matter jurisdiction, the case shall be remanded.* An order remanding the case may require payment of just costs and any actual expenses, including attorney fees, incurred as a result of the removal. A certified copy of the order of remand shall be mailed by the clerk to the clerk of the State court. The State court may thereupon proceed with such case.

B. Standard for Summary Judgment

Rule 56(c), Federal Rules of Civil Procedure, provides that summary judgment shall be rendered if the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show

that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." In ruling on a motion for summary judgment, it is the court's obligation to view the facts in the light most favorable to the adverse party and to allow the adverse party the benefit of all reasonable inferences to be drawn from the evidence. *Adickes v. S. H. Kress & Co.*, 398 U.S. 144, 157, 90 S. Ct. 1598, 1608 (1970); *Inland Oil and Transport Co. v. United States*, 600 F.2d 725, 727-28 (8th Cir.), *cert. denied*, 444 U.S. 991, (1979).

If there is no genuine issue about any material fact, summary judgment is proper because it avoids needless and costly litigation and promotes judicial efficiency. *Roberts v. Browning*, 610 F.2d 528, 531 (8th Cir. 1979); *United States v. Porter*, 581 F.2d 698, 703 (8th Cir. 1978). The summary judgment procedure is not a "disfavored procedural shortcut." Rather, it is "an integral part of the Federal Rules as a whole." *Celotex Corp. v. Catrett*, 106 S. Ct. 2548, 2555 (1986); *see also City of Mt. Pleasant v. Associated Electric Cooperative. Inc.*, 838 F.2d 268, 273 (8th Cir. 1988). Summary judgment is appropriate against a party who fails to make a showing sufficient to establish that there is a genuine issue for trial about an element essential to that party's case, and on which that party will bear the burden of proof at trial. *Celotex*, 106 S. Ct. at 2553.

The moving party bears the initial burden of demonstrating by reference to portions of pleadings, depositions, answers to interrogatories and admissions on file, together with affidavits, if any, the *absence* of genuine issues of material fact. However, the moving party *is not required* to support its motion with affidavits or other

similar materials *negating* the opponent's claim. *Id.* (emphasis added).

The nonmoving party is then required to go beyond the pleadings and by affidavits, depositions, answers to interrogatories and admissions on file, designate specific facts showing that there is a genuine issue for trial. *Id.* A party opposing a properly supported motion for summary judgment cannot simply rest on allegations and denials in his pleading to get to a jury without any significant probative evidence tending to support the complaint. *Anderson v. Liberty Lobby, Inc.*, 106 S. Ct. 2505, 2510 (1986).

A genuine issue of material fact exists "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Id.* The evidence favoring the nonmoving party must be more than "merely colorable." *Id.* at 2511. When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show there is some metaphysical doubt as to the material facts. *Matsushita Elec. Indus. Co. v. Zenith Radio*, 106 S. Ct. 1348, 1356 (1986) (footnote omitted).

The inquiry to be made mirrors the standard for a directed verdict: whether the evidence presented by the party with the onus of proof is sufficient that a jury could properly proceed to return a verdict for that party. *Anderson v. Liberty Lobby* at 2511. Essentially, the question in ruling on a motion for summary judgment and on a motion for directed verdict is whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law. *Id.* at 2512.

III. Discussion

Plaintiffs' Motion to Remand and Defendant's Motion for Summary Judgment Will Be Denied Because Plaintiffs' Claims are Preempted by ERISA

Title 28 U.S.C. § 1441(a) provides that "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or defendants." District courts have original jurisdiction over "federal question" cases; that is, those cases "arising under the Constitution, laws, or treaties of the United States." See 28 U.S.C. § 1331. A case "arises under" federal law only when the plaintiff's well-pleaded complaint raises issues of federal law. *See Gully v. First Nat'l Bank*, 299 U.S. 109, 112-13, 57 S. Ct. 96, 97-98 (1936). The United States Supreme Court has adhered to the "well-pleaded complaint rule" even where a plaintiff's state law claim is preempted by federal law:

> [I]t is now settled law that a case may *not* be removed to federal court on the basis of a federal defense, including the defense of preemption, even if the defense is anticipated in the plaintiff's complaint, and even if both parties concede that the federal defense is the only question truly at issue.

Caterpillar Inc. v. Williams, 482 U.S. 386, 393, 107 S. Ct. 2425, 2430 (1987) (citation omitted).

One important exception to the well-pleaded complaint rule is that Congress may so completely preempt a particular area of state law that any civil complaint raising this select group of claims is necessarily federal in

character and, therefore, subject to removal. *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 63-64, 481 S. Ct. 1542, 1546 (1987).

In *Franchise Tax Board v. Construction Laborers Vacation Trust,* 463 U.S. 1, 25, 103 S. Ct. 2841, 2854 (1983), the Supreme Court concluded that ERISA does not completely preempt all state law claims: "Congress did not intend to pre-empt entirely every state cause of action relating to such plans [plans covered by ERISA]." However, ERISA may preempt the corresponding area of state law in such a decisive manner that a state law claim would be considered to arise under federal law. *See id.* at 24, 103 S. Ct. at 2854.

The mere fact that a state claim is preempted by ERISA, without more, does not convert the state claim into an action arising under federal law. *Id.* at 25-27, 103 S. Ct. at 2854-56; *see also Metropolitan Life,* 481 U.S. at 64, 107 S. Ct. at 1547. However, a preempted state claim that also comes "within the scope of § 502(A) of ERISA would be removable to federal district court even if an otherwise adequate cause of action were pleaded without reference to federal law."[2] *Franchise Tax Board,* 463 U.S. at 24-25, 103 S. Ct. at 2854-56.

In *Metropolitan Life,* 481 U.S. at 66, 107 S. Ct. at 1548, the Supreme Court stated:

> Congress has clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of § 502(a) [29

---

[2] Section 502(a), 29 U.S.C. § 1132(a), is set forth *supra* pp. 16-17.

> U.S.C. § 1132(a)] removable to federal court. . . . [T]hough it purports to raise only state law claims, [this suit] is necessarily federal in character. . . . It, therefore, arise[s] under the . . . laws . . . of the United States, . . . and is removable to federal court by the defendants. . . .

Thus, to determine whether plaintiffs' case is properly removable to federal court, I must first determine whether the claims asserted by plaintiffs, which are state common-law claims, are preempted by ERISA. Secondly, I must determine whether plaintiffs' claims are "within the scope of § 502(a)" of ERISA, thereby converting the state law claims to claims "arising under" federal law.

1. Plaintiffs' Claims are Preempted by ERISA

ERISA is a remedial statute through which Congress established a comprehensive federal scheme to regulate the creation and administration of employee benefit plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44, 107 S. Ct. 1549, 1551 (1987).[3] ERISA is designed to protect the interests of employees in obtaining vested benefits under established pension and welfare plans by imposing requirements on employers for reporting, disclosure, participation rights, vesting of rights to benefits, funding, fiduciary responsibilities and claims procedures. *Scott v.*

---

[3] The term "employee benefit plan" broadly includes any plan, fund or program maintained for the purpose of providing employees with a wide spectrum of benefits such as pension, medical, accident, disability, death, unemployment, or vacation benefits. *See* 29 U.S.C. § 1002(1).

Gulf Oil Corp., 754 F.2d 1499, 1501 (9th Cir. 1985) (citing *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1983)); *see also* 29 U.S.C. § 1021-1145. ERISA protects employers from inconsistent state and local regulation of such plans by an express provision preempting all state laws that "relate to" employee benefit plans. *Id* (citing § 514(a) of ERISA, 29 U.S.C. § 1144).

Section 514(a) of ERISA states:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede *any and all State laws insofar as they may now or hereafter relate to any employee benefit plan* described in section 1003(a) of this title and not exempt under section 1003(b) of this title. . . .

28 U.S.C. § 1144(a) (emphasis added). "The question of whether a certain state action is preempted by federal law is one of congressional intent." *Pilot Life Ins.*, 481 U.S. at 45, 107 S. Ct. at 1552 (citations omitted); *FMC Corp. v. Holliday*, 111 S. Ct. 403, 407 (1990).

In *Pilot Life*, the plaintiff asserted contract and tort claims under common law for the alleged improper processing of a claim for benefits under an employee benefit plan. The Supreme Court concluded that ERISA preempts all state common law causes of action that assert improper processing of claims under a benefit plan regulated by ERISA. *Id.* at 47, 107 S. Ct. at 1553. ERISA's preemption provision is not limited to state laws that are specifically designed to affect employee benefit plans but extends to common law causes of action as well. *Id.* at 46, 107 S. Ct. at 1553. The ERISA preemption provision is

"deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern.' " *Id.* at 46, 107 S. Ct. at 1552 (citations omitted); *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. 478, 482 (1990).

The phrase "relates to" in § 514(a) must be given its "broad common-sense meaning." *Pilot Life*, 481 U.S. at 47, 107 S. Ct. at 1553 (quoting *Metropolitan Life*, 471 U.S. at 739, 105 S. Ct. at 2389). A state law " 'relates to a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan.' " *Id.* (quoting *Metropolitan Life*, 471 U.S. at 739, 105 S. Ct. at 2389 and *Shaw*, 463 U.S. at 97, 103 S. Ct. at 2900).

In *Ingersoll-Rand Co.*, the plaintiff asserted a state common law claim alleging that he was "unlawfully discharged to prevent his attainment of benefits under a plan covered by ERISA." 111 S. Ct. at 481. The Supreme Court again emphasized that preemption under § 514(a) should be applied expansively. The Supreme Court concluded:

> We have no difficulty in concluding that the cause of action which the Texas Supreme Court recognized here – a claim that the employer wrongfully terminated plaintiff primarily because of the employer's desire to avoid contributing to or paying benefits under the employee's pension fund – 'relate[s] to' an ERISA-covered plan within the meaning of § 514(a), and is therefore pre-empted.

Id. at 483.

Although preemption under ERISA is very broad, the Supreme Court has observed that "[s]ome state actions may affect employee benefit plans in too tenuous, remote,

or peripheral a manner to warrant a finding that the law "relates to" the plan. *Shaw*, 463 U.S. at 100 n.21, 103 S. Ct. at 2901 n.21; *see also Mackey v. Lanier Collections Agency & Serv., Inc.*, 108 S. Ct. 2182, 2187 (1988) ("[L]awsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are not preempted by ERISA); *Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1564 (11th Cir. 1987); *see, e.g., Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 145 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989) (Connecticut escheat law not preempted); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1465-70 (5th Cir. 1986) (corporate officer's fiduciary duties to shareholders not preempted simply because employee benefit plan is shareholder); *Lane v. Goren*, 743 F.2d 1337, 1339-41 (9th Cir. 1984) (state anti-discrimination laws apply to employees of benefit plan); *Bowen v. Bowen*, 715 F.2d 559, 560-61 (11th Cir. 1983) (per curiam) (garnishment of spouse's benefit plan income to enforce maintenance award not preempted); *American Tel. & Tel. Co. v. Merry*, 592 F.2d 118, 121 (2d Cir. 1979) (state garnishment of spouse's pension income to enforce maintenance and support orders not preempted).

Claims based on state common-law doctrines that do not explicitly refer to employee benefit plans are nonetheless preempted when the claims *arise from the administration of such plans. See, e.g., Settles v. Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991) (although the plaintiff was not seeking benefits under the employee benefit plan, the "factual basis for each of plaintiff's state law

claims directly concern[ed] the alleged improper administration of the benefit plan;" therefore, plaintiff's claims were preempted because they "relate[d] to" an employee benefit plan covered by ERISA.); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1564 (11th Cir. 1987) ("[I]f a state law claim arises out of the administration of benefits under [an employee benefit plan], the claim is preempted" by ERISA.); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419, 421 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (holding that "state laws, insofar as they are invoked by beneficiaries claiming relief for injuries arising out of the administration of employee benefit plans, 'relate to' such plans and . . . are preempted by ERISA."); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1504 (9th Cir. 1985) ("[P]reemption of state law claims by ERISA depends *on the conduct to which such law is applied, not on the form or label of the law.*") (citations omitted).

Plaintiffs in this case do not make a direct claim for contractual benefits under the Group Medical Plan. However, plaintiffs are asserting claims that *arise from the administration of that Plan.*

Plaintiffs allege that Buddy Kuhl died as a result of defendant's cancellation of Kuhl's heart surgery. Specifically, plaintiffs allege that Buddy Kuhl was scheduled for heart bypass surgery at Barnes Hospital in St. Louis on July 6, 1989. On June 20 or 21, 1989, Lincoln National received a telephone call from Barnes Hospital requesting pre-certification review. In Lincoln National's judgment, the request did not satisfy requirements under the Plan for pre-certification because the surgery was to be performed by non-participating physicians at a hospital that was not associated with Lincoln National. Thus, Lincoln

National did not pre-certify payment but instead requested additional information in the form of a second medical opinion concerning the necessity of the surgery. Lincoln National admits, for the purpose of this motion, that its refusal to pre-certify had the effect of cancelling the July 6, 1989, surgery.

Plaintiffs argue that by taking these actions, Lincoln National tortiously interfered with the contractual relationship between Buddy Kuhl and his doctors. They also contend that Lincoln National is liable for medical malpractice because it assumed the role of Buddy Kuhl's physician by making decisions about proper medical treatment. Also, plaintiffs allege that Lincoln National intentionally inflicted emotional distress on Buddy Kuhl's wife because she was aware that Lincoln National "cancelled" Kuhl's surgery, was present when Kuhl was informed in December [sic] 1989 that his heart could no longer withstand surgery and that a transplant was his only option and was present when Kuhl collapsed and died while waiting for a heart to become available. Finally, plaintiffs allege that Lincoln National breached its contract with Belger, of which Buddy Kuhl was a third-party beneficiary, by refusing to pre-certify the surgery scheduled for July 6, 1989.

According to the normal meaning of the statutory words "relate to," each of plaintiffs' claims "has a connection with" the Plan or, more specifically, each claim "arises from the administration" of the Plan. Plaintiffs' claims are based on the manner in which Lincoln National responded to the request for "Pre-certification" of Buddy Kuhl's heart surgery. Artful pleading by characterizing Lincoln National's actions in refusing to pay for

the surgery as "cancellation" or by characterizing the same administrative decisions as "malpractice" does not change the fact that plaintiffs' claims are based on the contention that Lincoln National improperly processed Kuhl's claim for medical benefits. Thus, plaintiffs' claims "relate to" the Plan and are preempted by § 514(a).

Although Lincoln National admits that its refusal to pre-certify the surgery caused it to be cancelled, plaintiffs' claims would be preempted even if somebody else actually cancelled the surgery. When Lincoln National communicated to Barnes Hospital its refusal to pre-certify payment of Kuhl's medical expenses for the surgery, the surgery was cancelled by someone, most likely Barnes Hospital. This cancellation was a direct result of Lincoln National's administration.

This conclusion is supported by the sound reasoning of the court in *Holmes v. Pacific Mutual Life Insurance Co.*, 706 F. Supp. 733 (C.D. Cal. 1989), which involved a factual situation very similar to this case. There, the plaintiff was a participant in an employee medical benefit plan that was covered by ERISA and administered by the defendant. The plaintiff developed a life-threatening liver disorder for which a liver transplant was the only cure. Arrangements were made for the transplant surgery to be performed at the UCLA Medical Center. When the UCLA Medical Center asked the defendant whether the medical benefit plan covered the cost of the surgery, the defendant erroneously stated that it did. After tentative arrangements for surgery were made, the plaintiff was required to wait until a transferable liver was located. When a liver became available, the UCLA Medical Center again called the defendant to verify that the plan covered

the cost of the surgery. At that time, the defendant correctly answered that it did not and the surgery was cancelled. The plaintiff then determined that she had other medical coverage and again made arrangements for surgery, but, before another suitable liver was found, she died. *Id.* at 734.

The plaintiff filed a petition in state court asserting various state law claims. The defendant removed the case to federal district court based on federal question jurisdiction under ERISA. The plaintiff then sought remand urging that there was no ERISA claim stated in the petition. The defendant then moved for summary judgment on the ground that ERISA preempted the plaintiff's state law claims because they were based entirely on representations made by the defendant acting in its capacity as the plan administrator. *Id.*

The court held that the plaintiff's state law claims were preempted because they were caught within the "sweep" of ERISA. In reaching this holding, the court noted that ERISA preemption is designed to shield ERISA employee benefit plans from unforeseen liabilities, including liabilities arising from claims such as the plaintiff's. *Id.* at 735. The court also stated that "were it not for the decision in *Pilot Life,* it might be argued that ERISA does not require preemption of [state law actions] against independent plan administrators since payments of liabilities would not come from the [plan's] fund nor appear at first blush to disturb [the] actuarial assumptions for funding [of the plan]." *Id.* at 36. However, the court noted that *Pilot Life* "wisely settled the principle that ERISA requires preemption of [state law] actions against plan administrators as well as [against] plans themselves.

Were this not the case, the ultimate cost of the liabilities imposed upon plan administrators inevitably would fall back on employers and the plans they sponsor." *Id.* at 36 & n.7. Such a result would neutralize the protection that the ERISA preemption provision provides to employers.

Plaintiffs rely heavily on cases holding that certain types of claims are too tenuous or too remote to warrant preemption. However, because none of those cases involve the types of claims asserted in this case, they are not persuasive.[4]

Plaintiffs also rely on *Drinkwater v. Metropolitan Life Insurance Co.*, 846 F.2d 821, 825 (1st Cir. 1988), *cert. denied*, 488 U.S. 909 (1988), to support their emotional distress claim. The court in *Drinkwater* stated in dicta that a wife's claim for emotional distress which resulted from an administrator's denial of benefits to her husband under an ERISA-covered plan was not preempted by ERISA. The court nevertheless granted the defendant's summary judgment motion because the plaintiff failed to show that she suffered physical injury, a necessary element of an emotional distress claim.

I am not persuaded by *Drinkwater* because there is ample, well-reasoned caselaw that directly contradicts it. *See, e.g., Johnson v. District 2 Marine Engineers Beneficial Assoc.*, 857 F.2d 514, 517-18 (9th Cir. 1988); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1989), *cert. denied*, 476 U.S. 1170 (1990). Furthermore, the court's conclusion in *Drinkwater* does not apply in this case. Here,

---

[4] These cases are referred to *supra* p. 14.

plaintiffs' alleged emotional distress claim arises *directly* from Lincoln National's *administration* of Plan.

Thus, I conclude that all of plaintiffs' claims are preempted under § 514(a). Unless these claims are within the scope of § 502(a) of ERISA, they must be dismissed.

2. Plaintiffs' claims are not "within the scope" of § 502 (a) of ERISA

Section 502(a) of ERISA, 29 U.S.C. § 1132(a), provides:

> A civil action may be brought –
>
> (1) by a participant or beneficiary –
>
> (A) for the relief provided for in subsection (c) of this section, or
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provisions of this subchapter or the terms of the plan, of (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

> (4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;
>
> (5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or
>
> (6) by the Secretary to collect any civil penalty under subsection (i) of this section.

The subsection that is most applicable to this case is § 502(a)(1)(B).[5]

The allegations in plaintiffs' Complaint and the facts presented in connection with the summary judgment do not suggest that plaintiffs seek to recover benefits due under the terms of the group medical plan, to enforce Buddy Kuhl's rights under the plan at the time pre-certification approval was sought or to clarify Kuhl's rights to future benefits under the terms of the plan.

---

[5] Section 502(a)(1)(A) is not applicable because subsection (c) provides for suing a plan administrator if the administrator fails to furnish requested information. Sections 502(a)(5) and 502(6) are not applicable because civil actions may be brought under those sections only by the Secretary of Labor. Section 502(a)(2) does not apply because plaintiffs do not allege any claims against defendant based on breach of duty under 29 U.S.C. § 1109. Section 502(a)(3) is not relevant because plaintiffs do not seek equitable relief. Section 502(a)(4) is also not applicable because plaintiffs do not seek relief for defendant's failure to furnish information in defendant's Internal Revenue Service registration statement.

Accordingly, plaintiffs' claims are not within the scope of § 502(a).

IV. Conclusion

Because plaintiffs' claims are preempted by ERISA, plaintiffs' Motion to Remand will be denied. Also, because plaintiffs' claims are preempted by ERISA but do not fall within the scope of § 502(a), this court has no authority under ERISA to consider plaintiffs' claims. Thus, defendant's Motion for Summary Judgment will be granted.

V. Order

For the foregoing reasons, it is ordered that:

1) plaintiffs' Motion to Remand is denied;

2) defendant's Motion for Summary Judgment is granted and summary judgment is entered in favor of defendant and against plaintiffs; and

3) this case is dismissed.

/s/ D. Brook Bartlett
D. BROOK BARTLETT
UNITED STATES DISTRICT JUDGE

Kansas City, Missouri
December 26, 1991.

United States District Court
WESTERN DISTRICT OF MISSOURI

Mary Kuhl, et al.,

Plaintiffs,

V.

Lincoln National Health Plan of Kansas City, Inc.,

Defendant.

JUDGMENT IN A CIVIL CASE

(Filed Dec. 26, 1991)

CASE NUMBER: 91-0330-CV-W-9

— **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

X **Decision by Court.** This action came to /consideration before the Court. The issues have been /considered and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

1) plaintiffs' Motion to Remand is denied;

2) defendant's Motion for Summary Judgment is granted and summary judgment is entered in favor of defendant and against plaintiffs; and

3) this case is dismissed.

December 26, 1991
Date

R. F. Connor
Clerk

/s/ Tina Duer
(By) Deputy Clerk

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

MARY KUHL, et al.,	)	
Plaintiffs,	)	
v.	)	No.
LINCOLN NATIONAL HEALTH PLAN OF KANSAS CITY, INC.,	)	91-0330-CV-W-9
Defendant.	)	

ORDER GRANTING PLAINTIFFS' MOTION TO RECONSIDER, DENYING PLAINTIFFS' MOTION TO ALTER OR AMEND JUDGMENT, AFFIRMING THE DECEMBER 23, 1991, ORDER DENYING PLAINTIFFS' MOTION TO REMAND, GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND DENYING PLAINTIFFS' MOTION FOR LEAVE TO AMEND COMPLAINT
(Filed June 15, 1992)

For the reasons stated at the June 10, 1992, hearing, it is ORDERED that:

1) plaintiffs' Motion to Reconsider is granted;

2) plaintiffs' Motion to Alter or Amend Judgment to Reconsider is denied;

3) plaintiffs' Motion for Leave to Amend Complaint is denied; and

4) the December 23, 1991, Order Denying Plaintiffs' Motion to Remand and Granting Defendant's Motion for Summary Judgment is affirmed.

/s/ D. Brook Bartlett
D. BROOK BARTLETT
UNITED STATES DISTRICT JUDGE

Kansas City, Missouri

June 15, 1992.

United States District Court
WESTERN DISTRICT OF MISSOURI

Mary Kuhl, et al.,

Plaintiffs,

V.

Lincoln National Health Plan of Kansas City, Inc.,

Defendant.

JUDGMENT IN A CIVIL CASE

(Filed June 15, 1992)

CASE NUMBER: 91-0330-CV-W-9

— **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

X **Decision by Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

1) plaintiffs' motion to reconsider is granted;

2) plaintiffs' motion to alter or amend judgment to reconsider is denied;

3) plaintiffs' motion for leave to amend complaint is denied;

4) the December 23, 1991, Order denying plaintiffs' motion to remand and granting defendant's motion for summary judgment is affirmed.

June 15, 1992
Date

R. F. Connor
Clerk

/s/ Tina Duer
(By) Deputy Clerk

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

MARY KUHL, et al.,	)	
Plaintiffs,	)	
v.	)	No.
LINCOLN NATIONAL HEALTH PLAN OF KANSAS CITY, INC.,	)	91-1146-CV-W-9
Defendant.	)	

ORDER GRANTING DEFENDANT'S MOTION TO DISMISS PLAINTIFFS' COMPLAINT AND DISMISSING CASE
(Filed June 15, 1992)

For the reasons stated at the June 10, 1992, hearing, it is ORDERED that:

1) defendant's Motion to Dismiss Plaintiffs' Complaint is granted; and

2) this case is dismissed.

/s/ D. Brook Bartlett
D. BROOK BARTLETT
UNITED STATES DISTRICT JUDGE

Kansas City, Missouri
June 15, 1992.

United States District Court
WESTERN DISTRICT OF MISSOURI

Mary Kuhl, et al.,

Plaintiffs,

V.

Lincoln National Health Plan of Kansas City, Inc.,

Defendant.

JUDGMENT IN A CIVIL CASE

(Filed June 15, 1992)

CASE NUMBER: 91-1146-CV-W-9

__ **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

X **Decision by Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED

1) defendant's motion to dismiss plaintiffs' complaint is granted; and

2) this case is dismissed.

June 15, 1992
Date

R. F. Connor
Clerk

/s/ Tina Duer
(By) Deputy Clerk

29 U.S.C. § 1144(a)

Other Laws

(a) **Supersedure; effective date.** Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USCS § 1003(a)] and not exempt under section 4(b) [29 USCS § 1003(b)]. This section shall take effect on January 1, 1975.

Supreme Court, U.S.
FILED
DEC. 15 1993
OFFICE OF THE CLERK

No. 93-755

In The

Supreme Court of the United States

October Term, 1993

MARY KUHL, BUDDY KUHL, JR. AND MARNIE K. KUHL,

Petitioners,

v.

LINCOLN NATIONAL HEALTH PLAN OF KANSAS CITY, INC.,

Respondent.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

MARK E. JOHNSON*
R. CHRISTOPHER ABELE
TERRY E. TYRRELL
WILLIAM E. HANNA
MORRISON & HECKER
2600 Grand Avenue
Kansas City, Missouri 64108-4606
816-691-2600

Attorneys for Respondent Lincoln National Health Plan of Kansas City, Inc.

*Counsel of Record

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1. Whether the court of appeals correctly decided that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, preempts state law claims, including tort claims, against an ERISA plan administrator?

2. Whether the district court and court of appeals properly considered Lincoln National's motion for summary judgment by reviewing the facts in the light most favorable to petitioners?

LIST OF PARTIES

Petitioner Mary Kuhl

Petitioner Buddy Kuhl, Jr.

Petitioner Marnie K. Kuhl

Respondent Lincoln National Health Plan of Kansas City, Inc.*

---

*The following corporations are related to Lincoln National Health Plan of Kansas City, Inc.: Lincoln National Corporation; TakeCare, Inc; TakeCare Administrative Services Corporation; The Medical Protective Company; Lexington Insurance Company; Kansas Health Care Stabilization Fund; Kansas Medical Mutual Insurance Company, on behalf of The Kansas Health Care Provider Insurance Availability Plan; Reliance National Insurance Company; National Union Fire Insurance Company; American States Insurance Company; Chubb Group of Insurance Companies.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

LIST OF PARTIES ii

TABLE OF CONTENTS iii

TABLE OF AUTHORITIES v

STATUTES AND RULES INVOLVED 1

STATEMENT OF THE CASE 1

A. Factual Background 1

B. Proceedings In The Lower Courts 5

REASONS FOR DENYING THE WRIT 9

I. THE COURT OF APPEALS PROPERLY FOLLOWED THIS COURT'S PRIOR DECISIONS INTERPRETING ERISA'S PREEMPTIVE SCOPE 10

A. Substantial Precedent From This Court And Other Circuit Courts Supports The Court Of Appeals' Decision 11

B. The Eighth Circuit's Decision Does Not Conflict With Any Supreme Court Decision 14

C. As In *Corcoran*, Certiorari Is Not Warranted Here 17

D. Federal Courts Consistently Rule That ERISA Preempts Wrongful Death Claims for Medical Malpractice 19

E. The Eighth Circuit's Decision Furthers The Purposes Behind ERISA's Preemption Provision 22

TABLE OF CONTENTS – Continued

Page

F. The Eighth Circuit Correctly Ruled That ERISA Preempts Petitioner Mary Kuhl's Emotional Distress Claim 25

II. THE COURT OF APPEALS PROPERLY CONSIDERED THE EVIDENCE IN AFFIRMING THE DISTRICT COURT'S GRANT OF LINCOLN NATIONAL'S MOTION FOR SUMMARY JUDGMENT 26

A. There Exists No Issue Of Material Fact 26

B. The District Court's Ruling Was Correct ... 28

C. The Eighth Circuit's Ruling Was Correct ... 29

CONCLUSION 30

TABLE OF AUTHORITIES

Page

CASES

Adickes v. S.H. Kress & Co., 398 U.S. 144 (1970) 28

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981) 13, 22

American Progressive Life & Health Ins. Co. v. Corcoran, 715 F.2d 784 (2d Cir. 1983) 12

Anderson v. Liberty Lobby, Inc., 477 U.S. 242 (1986) 27, 28

Champion Int'l Corp. v. Brown, 731 F.2d 1406 (9th Cir. 1984) 12

Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992) ... *passim*

District of Columbia v. Greater Washington Bd. of Trade, 113 S. Ct. 580 (1992) 12

Drinkwater v. Metropolitan Life Ins. Co., 846 F.2d 821 (1st Cir. 1988), *cert. denied*, 488 U.S. 909 (1988) 25

FMC Corp. v. Holliday, 498 U.S. 52 (1990) 12

Folz v. Marriott Corp., 594 F. Supp. 1007 (W.D. Mo. 1984) 25

Ft. Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987) 15

General Motors Corp. v. Buha, 623 F.2d 455 (6th Cir. 1980) 12

Holland v. Burlington Indus., Inc., 772 F.2d 1140 (4th Cir. 1985), *aff'd*, 477 U.S. 901 (1986) 13, 26

Holmes v. Pacific Mut. Life Ins. Co., 706 F. Supp. 733 (C.D. Cal. 1989) 19, 20, 21, 22

TABLE OF AUTHORITIES – Continued

Page

Hotel and Restaurant Employees and Bartenders Int'l Union Local 54 v. Danzinger, 709 F.2d 815 (3d Cir. 1983), *vacated on other grounds*, 468 U.S. 491 (1984) 12

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990) ..... *passim*

Inlend Oil and Trans. Co. v. United States, 600 F.2d 725 (8th Cir.), *cert. denied*, 444 U.S. 991 (1979) 28

Johnson v. District 2 Marine Eng'rs Beneficial Ass'n, 857 F.2d 514 (9th Cir. 1988) 9, 25

Mackey v. Lanier Collections Agency, 486 U.S. 825 (1988) 14, 15, 16

Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134 (1985) 22, 25

Mertens v. Hewitt Assocs., 113 S. Ct. 2063 (1993) ... 6, 9, 22

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) 12

Meyer v. Employers Health Ins. Co., 722 F. Supp. 547 (E.D. Wis. 1989) 25

Pane v. RCA Corp., 667 F. Supp. 168 (D.N.J. 1987), *aff'd*, 868 F.2d 631 (3d Cir. 1989) 25

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) ..12, 13

Powell v. Chesapeake and Potomac Tel. Co., 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) 9, 25, 26

Rollo v. Maxicare of Louisiana, Inc., 698 F. Supp. 111 (E.D. La. 1988) 25

TABLE OF AUTHORITIES – Continued

Page

Settles v. Golden Rule Ins. Co., 715 F. Supp. 1021 (D. Kan. 1989), *aff'd*, 927 F.2d 505 (10th Cir. 1991) 19, 21, 22

Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983) 11, 12, 24

Smith v. Electronical Data Sys. Corp., 657 F. Supp. 1242 (D. Colo. 1987) 25

Stone and Webster Eng'g Corp. v. Ilsley, 690 F.2d 323 (2d Cir. 1982), *aff'd*, 463 U.S. 1220 (1983) 12

STATUTES

28 U.S.C. § 1441(b) 5

29 U.S.C. § 1001, *et seq* ..... i, 1

29 U.S.C. § 1132(a)(3) 6, 7, 8, 9

29 U.S.C. § 1144(a), ERISA Section 514(a) 1, 11, 13

OTHER AUTHORITIES

H.R. Rep. No. 533, 93rd Cong. 1st Sess. 8, reprinted in 1974 U.S. Code Cong. & Admin. News 4639, 4646 24

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

This case involves claims made with respect to the death of a participant in an ERISA-covered group health plan. Respondent Lincoln National Health Plan of Kansas City, Inc. ("Lincoln National") was the plan administrator. All relevant actions of Lincoln National were taken in the course of determining whether benefits were payable under the plan. Petitioners' claims therefore are preempted, and their arguments to the contrary defy this Court's well-established precedent, which has been applied as recently as last year to deny certiorari in a case strikingly similar to this case. Accordingly, Lincoln National respectfully requests that this Petition for Writ of Certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit be denied.

STATUTES AND RULES INVOLVED

This case involves the application of the preemptive effect of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.*, particularly § 514(a), 29 U.S.C. § 1144(a).

STATEMENT OF THE CASE

A. *Factual Background.*

There is no dispute as to any of the facts material to the district court's grant of summary judgment, and the affirmance of that ruling by the Eighth Circuit Court of Appeals.[1] Buddy Kuhl was an employee of Belger Cartage Services, Inc. ("Belger"), and was a participant in the

---

[1] Lincoln National takes issue with many of the factual characterizations made by petitioners. However, because

Belger Group Medical Plan ("Belger Plan"), a group medical plan sponsored by Belger. Lincoln National was the administrator of the Belger Plan, which is both an "employee benefit plan" and an "employee welfare benefit plan" within the meaning of ERISA. As the court of appeals noted, "Lincoln National Health Plan is an 'independent physician' HMO, which means that it pays independent physicians, hospitals, and other health care providers to render medical services for its members." *See* Petitioners' Appendix ("P.App.") at A-2. Mr. Kuhl never was examined or treated by any physician or nurse employed by Lincoln National, and Lincoln National never rendered medical services to Mr. Kuhl. Lincoln National's responsibilities were limited to decisions respecting the payment of claims or benefits under the Belger Plan.

Mr. Kuhl, as a Belger employee, and his dependents, Mary and Marnie Kuhl, agreed to the terms of and became members in the Belger Plan. Pursuant to the contract between Lincoln National and Belger, Lincoln National paid for medical services provided to Belger employees according to the restrictions, limitations and exclusions of the Belger Plan. As the court of appeals highlighted, "Lincoln National is not contractually obligated to pay for medical services rendered outside the 'Service Area' of the Lincoln National network or for medical services rendered by personnel not participating in the Lincoln National network." P.App. at C-2. The principal document governing the Belger Plan provided:

> "Service Area" is the geographical area within which HMO's covered services are available.

---

petitioners cannot dispute any fact material to ERISA's preemptive scope, the extraneous factual allegations made by petitioners will not be addressed here.

> This includes the counties of Jackson, Clay, Platte, Cass, Buchanan, Ray and LaFayette in Missouri and Johnson and Wyandotte in Kansas. The Service Area may be revised by HMO as HMO deems necessary.
>
> * * *
>
> Except for Emergency Services as provided in Section L,[2] these services and benefits are available only in the Service Area and only if, and to the extent that, they are provided, prescribed, or directed by a Plan Physician in accordance with the terms of the Group Medical and Hospital Service Certificate.

The district court ruled that "Lincoln National is not obligated to automatically pay for medical services rendered outside the 'Service Area' of the Lincoln National network." P.App. at C-2.

Lincoln National became involved with considering whether payment would be authorized under the Belger Plan for Mr. Kuhl's proposed surgery at Barnes Hospital ("Barnes") of St. Louis, Missouri in June, 1989. At that time, Barnes contacted Lincoln National to verify that the Belger Plan would pay for Mr. Kuhl's surgery scheduled to take place on July 3, 1989. Lincoln National did not initially certify benefits for the surgery because Barnes was outside the Lincoln National "Service Area" as defined by the Belger Plan.[3] Lincoln National, after further consideration of Mr. Kuhl's precertification request,

---

[2] The "Emergency Services" exception, as defined in the Belger Plan, did not apply in this case.

[3] Lincoln National offered a PPO ("preferred provider program") option under the Belger Plan, which provided benefits regardless of whether a doctor or institution was a "preferred provider", although the amount of the benefit was less if a plan member chose a non-preferred provider. Mr. Kuhl did not choose the PPO option, instead choosing Lincoln National's

authorized payment of benefits for the non-"Service Area" surgery, but the surgery was not performed and Mr. Kuhl died while awaiting a heart transplant. Presumably the physicians who in fact were caring for Mr. Kuhl throughout this time period did not believe there was a risk in the delay. Petitioners have not made any claims against these parties.

As stated by the district court, "Lincoln National conducts a precertification review of hospital admissions. In the precertification review, Lincoln National determines whether a particular provider or hospitalization is covered by the Plan." P.App. at C-3. The precertification procedure under which Mr. Kuhl's surgery allegedly was "cancelled" was a condition precedent to the payment of benefits under the Belger Plan, and Lincoln National's precertification process was a claims administrative function under the Belger Plan. Lincoln National made such decisions by reviewing coverage for benefits and determining whether a particular procedure or hospitalization met the requirements of Lincoln National's contract with the employer and participant.

These facts, although ignored almost entirely by petitioners in their attempt to characterize Lincoln National's administrative actions as "medical malpractice", are the only facts material to the dispositive issue in this case – ERISA preemption. Petitioners have not disputed any of these material facts.

HMO option which provides a higher benefit percentage, but *only* for certain physicians and institutions within the Belger Plan's "Service Area."

B. *Proceedings In The Lower Courts.*

Petitioners originally filed suit against Lincoln National in the Circuit Court of Jackson County, Missouri, alleging four causes of action: (1) medical malpractice; (2) tortious interference with contractual relations; (3) intentional infliction of emotional distress; and (4) breach of contract.[4] Petitioners did not allege that any of their claims were made under ERISA.

Lincoln National removed the case to federal court pursuant to 28 U.S.C. § 1441(b) and ERISA's "complete preemption doctrine." Petitioners sought remand, arguing ERISA preemption did not apply. Lincoln National opposed petitioners' motion to remand, and subsequently moved for summary judgment on the grounds of ERISA preemption.

1. *The District Court's Order In Kuhl I.*

In an order dated December 26, 1991, the district court granted Lincoln National's summary judgment motion and denied petitioners' motion to remand. Specifically, the district court ruled that ERISA preempts petitioners' alleged causes of action:

> Plaintiffs in this case do not make a direct claim for contractual benefits under the Group Medical Plan. However, plaintiffs are asserting claims that *arise from the administration of that Plan*. . . .

---

[4] As set forth below, petitioners filed two separate lawsuits against Lincoln National. The first suit was captioned *Mary Kuhl, Marnie Kuhl, and Buddy Kuhl, Jr. v. Lincoln National Health Plan of Kansas City, Inc.*, Case No. 91-0330-CV-W-9, and will be referred to hereafter as "Kuhl I". Petitioners also filed a second suit captioned *Mary Kuhl, Marnie Kuhl and Buddy Kuhl, Jr., v. Lincoln National Health Plan of Kansas City, Inc.*, Case No. 91-1146-CV-W-9, which will be referred to hereafter as *"Kuhl II"*.

> According to the normal meaning of the statutory words "relate to", each of plaintiffs' claims "has a connection with" the Plan or, more specifically, each claim "arises from the administration of the Plan." Plaintiffs' claims are based on the manner in which Lincoln National responded to the request for "Pre-certification" of Buddy Kuhl's heart surgery.

P.App. at C-15, 16 (emphasis in original). The district court then concluded:

> Artful pleading by characterizing Lincoln National's actions in refusing to pay for the surgery as "cancellation" or by characterizing the same administrative decisions as "malpractice" does not change the fact that plaintiffs' claims are based on the contention that Lincoln National improperly processed Kuhl's claims for medical benefits. Thus, plaintiffs' claim "relate to" the Plan and are preempted by § 514(a).

P.App. at C-16, 17. Finally, even though petitioners made no attempt to allege a cause of action under ERISA, the district court reviewed the complaint to determine if petitioners could properly state an ERISA-based claim. After discussing every potential subsection under which petitioners even arguably could allege an ERISA-based cause of action, the court determined no ERISA claim existed. P.App. at C-21.[5]

---

[5] Petitioners make no claim to this Court that the district court or the court of appeals erred in determining that 29 U.S.C. § 1132(a)(3) does not provide for "extra-contractual relief," and do not seek certiorari to address this issue. Indeed, this Court's recent decision in *Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063 (1993), establishes that the rulings by the courts below were correct.

2. *Petitioners File Suit In Kuhl II.*

On December 27, 1991, one day after the Court issued its order in *Kuhl I*, petitioners filed suit in *Kuhl II* based upon facts and circumstances identical to those in *Kuhl I*. Petitioners alleged in their *Kuhl II* complaint that Lincoln National breached a fiduciary duty under ERISA.

Lincoln National moved to dismiss petitioners' complaint because, alternatively: (1) res judicata barred petitioners' claims; (2) petitioners had no cause of action under ERISA for any alleged breach of fiduciary duty; and (3) ERISA does not provide for extracontractual damages under 29 U.S.C. § 1132(a)(3).

3. *Petitioners Move To Amend Their Complaint In Kuhl I.*

After the district court dismissed the case in *Kuhl I* and entered judgment on Lincoln National's behalf, petitioners moved to amend their *Kuhl I* complaint. The "amended" complaint in *Kuhl I* was identical to the complaint filed by petitioners in *Kuhl II*, alleging a cause of action under ERISA.

4. *The District Court Denies Petitioners' Motion To Amend In Kuhl I And Dismisses Petitioners' Complaint In Kuhl II.*

Even after dismissing the *Kuhl I* complaint, the district court held oral argument to consider, among other issues: (1) petitioners' motion that the court reconsider its grant of summary judgment in *Kuhl I*; (2) petitioners' motion to amend in *Kuhl I*; (3) petitioners' claim that the district court should have "recharacterized" their state law claims in *Kuhl I* as claims under ERISA; and (4) Lincoln National's motion to dismiss in *Kuhl II*. At the conclusion of oral argument, the district court thoroughly

reviewed each issue and entered judgment from the bench. In addressing petitioners' argument regarding the scope of ERISA's preemptive force during oral argument, the district court stated:

> It makes no difference whether defendant cancelled the surgery or caused it to be cancelled by not agreeing to pay for it or by rescinding the previous certification or agreement it would pay for it. However one characterizes what happened, the end result is that whatever Lincoln National did it did in response to and as part of the procedures under the plan that were required before payment could be expected by the plan for the surgical procedure that was being contemplated. In fact, it was my belief that no matter how one characterizes the facts advanced by the plaintiffs, the facts involve the allegation or contention that defendant improperly processed a claim for benefits by doing things that it shouldn't have done, and/or not doing things it should have done. In any event, these actions were done by the administrator of the plan in response to a request for a claim for benefits.

The district court went on to deny petitioners' motion to amend in *Kuhl I*. Additionally, the court granted Lincoln National's motion to dismiss the *Kuhl II* complaint on three grounds: (1) the final judgment in *Kuhl I* was res judicata as to petitioners' complaint in *Kuhl II*; (2) applying the same reasoning that warranted summary judgment in *Kuhl I*, petitioners could state no claim under ERISA for breach of fiduciary duty; and (3) the "the other equitable relief" clause in 29 U.S.C. § 1132(a)(3) does not include monetary damages.

5. *The Eighth Circuit's Ruling.*

The Eighth Circuit Court of Appeals affirmed the district court's judgments in favor of Lincoln National.

Upon careful review of the facts, the Eighth Circuit held that petitioners' claims were preempted because all actions taken by Lincoln National were performed in its role as an ERISA plan administrator:

> Taking the facts in the light most favorable to the Kuhls, as we must for purposes of Lincoln National's motion for summary judgment, we are compelled to agree with the district court. Lincoln National became involved in the cancellation of the St. Louis surgery only after the Barnes Hospital staff requested a precertification review. Lincoln National's admission that it "cancelled" the surgery cannot be stretched to imply that Lincoln National went beyond the administration of benefits and undertook to provide Buddy Kuhl with medical advice. Although the surgery in St. Louis was unquestionably cancelled as a result of Lincoln National's decision not to precertify payment, the decision not to precertify payment relates directly to Lincoln National's administration of benefits.

P.App. at A-11. The Eighth Circuit also ruled that ERISA preempts petitioner Mary Kuhl's claim for intentional infliction of emotional distress, *citing Johnson v. District 2 Marine Eng'rs Beneficial Ass'n*, 857 F.2d 514 (9th Cir. 1988) and *Powell v. Chesapeake and Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986). Finally, relying upon this Court's decision in *Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063 (1993), the Eighth Circuit ruled that monetary damages are not available under section 1132(a)(3). The pending petition for certiorari followed.

REASONS FOR DENYING THE WRIT

The dispositive issue in this case has been addressed by this Court on several prior occasions: does ERISA preempt a state law cause of action against an ERISA plan

administrator for alleged improper processing of a claim for benefits? Because the answer to this question is affirmative, and because none of the facts material to the application of ERISA's preemptive scope are disputed, the findings of preemption by both the district court and court of appeals are correct as a matter of law.

Moreover, petitioners have not demonstrated any special or important reason why this Court should grant their petition. Petitioners fail to present any decisions of this Court or any other circuit court of appeals that conflict with the decision below. Rather, the decisions of both lower courts are consistent with established precedent from this Court and other federal appellate courts. Relying primarily on a series of cases decided by this Court, numerous courts uniformly have held that state law claims of the nature alleged in this case are preempted. Further, this Court recently denied certiorari in a case with issues similar, if not identical, to those present here. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992).

Petitioners also claim, without merit, that the lower courts incorrectly applied the legal standard applicable to motions for summary judgment. An examination of the opinion below demonstrates that in evaluating Lincoln National's motion, the court of appeals properly viewed all material facts in the light most favorable to petitioners, and that there is no dispute as to any fact material to ERISA's application.

I. THE COURT OF APPEALS PROPERLY FOLLOWED THIS COURT'S PRIOR DECISIONS INTERPRETING ERISA'S PREEMPTIVE SCOPE.

The decision of the court of appeals is legally correct and consistent with prior decisions by this Court and those of other circuit courts.

Petitioners try to deflect attention from Lincoln National's administration of the Belger Plan by emphasizing alleged facts which are irrelevant to the issue of whether ERISA preempts the state law claims. Petitioners cite cases which are legally and factually insufficient to support their petition. All Lincoln National's actions were taken in relation to the administration of the Belger Plan and, therefore, ERISA preempts petitioners' alleged causes of action.

A. Substantial Precedent From This Court And Other Circuit Courts Supports The Court Of Appeals' Decision.

This Court has directly addressed the application of ERISA's preemptive scope. *E.g., Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). In *Shaw*, the Court ruled that New York laws forbidding discrimination in employee benefit plans on the basis of pregnancy, and a law requiring employers to pay sick-leave benefits to employees unable to work because of pregnancy, were preempted by ERISA. This Court noted that "a law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97. Critically, the Court ruled that Congress used the "relate to" language in 29 U.S.C. § 1144(a) in its broad sense:

> to preempt only state laws specifically designed to effect employee benefit plans would be to ignore the remainder of § 514(a). It would have been unnecessary to exempt generally applicable state criminal statutes from preemption from § 514(a), for example, if § 514(a) applied only to state laws dealing specifically with ERISA plans.

Id.

It was further observed in *Shaw*, based on ERISA's legislative history, that the preemption clause was not

limited to matters specifically covered by ERISA, such as reporting, fiduciary responsibilities and the like. *Id.* at 98. ERISA preempts state laws that relate to employee benefit plans regardless of whether they directly conflict with substantive provisions of an ERISA plan. *Id.* By giving the "relate to" phrase in § 514(a) its "broad, common-sense meaning," *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985), it is clear that state law claims, including those in this case, are intended to be preempted within the parameters of section 514.[6] This Court has "repeatedly stated that a law 'relates to' a covered employee benefit plan for purposes of § 514(a) 'if it has a connection with or reference to such a plan.' " *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 583 (1992) (quoting *Shaw*, 463 U.S. at 97 (1983)); *see also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52, 58-59 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987).

---

[6] Indeed, the breadth of the preemptive effect of ERISA is evidenced by Congress' refusal to enact proposed legislation which would have allowed preemption only of state laws specifically dealing with employee benefit plans. *See Shaw*, 463 U.S. at 98-99, nn. 18, 19 and 20; *Champion Int'l Corp. v. Brown*, 731 F.2d 1406, 1409 (9th Cir. 1984) (broad preemption to prevent conflicting and inconsistent state regulation); *American Progressive Life & Health Ins. Co. v. Corcoran*, 715 F.2d 784, 786 (2d Cir. 1983) (sweeping preemptive effect); *Hotel and Restaurant Employees and Bartenders Int'l Union Local 54 v. Danzinger*, 709 F.2d 815, 830 (3d Cir. 1983) (preemption as broad as "relate to" language), *vacated on other grounds*, 468 U.S. 491 (1984); *Stone and Webster Eng'g Corp. v. Ilsley*, 690 F.2d 323, 329 (2d Cir. 1982) (Section 1141(a) clearly eliminates the threat of conflicting or inconsistent state laws), *aff'd*, 463 U.S. 1220 (1983); *General Motors Corp. v. Buha*, 623 F.2d 455, 459 (6th Cir. 1980) (preemption central to ERISA).

Petitioners' claims "relate to" Mr. Kuhl's participation in an employee benefit plan and the administration of that plan by Lincoln National. Therefore, based upon the broad interpretation of 29 U.S.C. § 1144(a), petitioners' various state law claims are preempted because they all arise out of alleged conduct taken in connection with the administration of an employee benefit plan.

In *Pilot Life*, this Court unanimously held that ERISA preempts state tort law and contract actions for improper processing of benefit claims under an ERISA plan. 481 U.S. at 48. The Court ruled "the express provisions of ERISA are deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern.' " *Id.* at 46 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). In *Pilot Life*, the Court flatly held that "ERISA's civil enforcement remedies were intended to be exclusive." *Id.* at 54. Under *Pilot Life*, any "state lawsuit asserting improper processing of a claim of benefits under an ERISA-regulated plan . . . is preempted by § 514(a)." *Id.* at 57. For this reason, the preemption clause has an "unparalelled breadth." *Holland v. Burlington Indus., Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *aff'd*, 477 U.S. 901 (1986).

Petitioners argue Lincoln National's initial refusal to precertify benefits for the surgery was a "cancellation" of the scheduled surgery. However, petitioners cannot validly dispute that this action, however described, was taken in the context of Lincoln National's role as the administrator of an ERISA plan and because Barnes Hospital was not within the Belger Plan's "Service Area." As the district court stated throughout oral argument:

> It [Mr. Kuhl's surgery] was cancelled because the insurance company said it wasn't going to pay for it. And the hospital certainly isn't going to go ahead and do an operation if the insurance

> company is saying I'm not going to pay for it. Now, that's what insurance companies do all the time . . . as I wrote in the first opinion, I don't think it makes any difference, actually, how you characterize it. . . . Your view just doesn't make any sense to me because it isn't supported by any facts.

Regardless of how petitioners wish to characterize Lincoln National's action in connection with the precertification request, the action taken by Lincoln National was in connection with Lincoln National's interpretation of benefits afforded under the terms and conditions of the Belger Plan. As such, Lincoln National's actions and obligations are governed by ERISA and petitioners' state law claims are preempted.

B. The Eighth Circuit's Decision Does Not Conflict With Any Supreme Court Decision.

Contrary to petitioners' assertion, the Eighth Circuit's decision does not conflict with any Supreme Court decision. Petitioners' reliance upon *Mackey v. Lanier Collections Agency*, 486 U.S. 825 (1988) is simply misplaced. *Mackey* already has been held by this Court to be distinguishable from, and therefore consistent with, the other Supreme Court decisions relied upon by the Eighth Circuit.

In *Mackey*, this Court affirmed a Georgia Supreme Court decision that a state statute barring garnishment of ERISA welfare plan benefits was preempted, while the general state garnishment law was not preempted. This Court held the anti-garnishment statute's "express reference to ERISA plans" suffices to bring it within the federal law's preemptive reach. *Id.* at 830. With respect to the general garnishment statute, however, this Court relied

on ERISA provisions and the statute's structure to conclude Congress did not intend to forbid state garnishment procedures against welfare plans. *Id.* at 831.

In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), this Court held ERISA preempts a state common law claim of wrongful discharge to prevent attainment of ERISA pension benefits. The Court noted that although it had recognized certain limits to ERISA preemption, citing *Mackey* and *Ft. Halifax Packing Co. v. Coyne*,[7] these limitations were not applicable in the case before it:

> We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan. Nor is the cost of defending this lawsuit a mere administrative burden. Here, the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension plan itself.

Ingersoll-Rand, 498 U.S. at 139. Here, as in *Ingersoll-Rand*, the existence of the Belger Plan not only is *a* critical factor, but the *only* reason Lincoln National had any dealings whatsoever with Mr. Kuhl. Because petitioners' alleged causes of action relate directly to the limitations, restrictions and exclusions of the Belger Plan, they are preempted by ERISA.

The Eighth Circuit explained why the limitation on preemption recognized in *Mackey* is not applicable in the present case:

> Under *Pilot Life*, any state law claim that Buddy Kuhl may have had against Lincoln National for

---

[7] 482 U.S. 1, 23 (1987) (holding that a state law which required payment of severance benefits was not preempted because the statute did not require the establishment or maintenance of an ongoing plan).

> its conduct in delaying the surgery scheduled for July 6, 1989, arose from Lincoln National's denial of benefits under the Belger Plan. The Kuhls' attempt to invoke *Mackey* and to characterize their claims as merely tangentially related to the Plan is unpersuasive. Accordingly, the Kuhls' state law claims through Buddy Kuhl "relate to" the Belger Plan and are preempted by ERISA.

P.App. at A-12. As in *Ingersoll-Rand*, the Court's inquiry in this case necessarily is directed to the Belger Plan, because the action which forms the basis of the alleged causes of action "arose from Lincoln National's denial of benefits under the Belger Plan." P.App. A-12.

Petitioners rely on *dicta* in *Mackey* which lists "run of the mill" state law claims not preempted by ERISA, including claims against plans for unpaid rent, unpaid attorneys' fees, and libel. *See Mackey*, 486 U.S. at 833 n.8. Petitioners' characterization of the instant claim as within the "run of the mill tort claim" category simply is without support from the *Mackey* decision itself, or from the Eighth Circuit. None of these examples is analogous here because they are totally unrelated to the performance by the defendant plan of any ERISA functions. The Eighth Circuit referenced the *Mackey* list of "run of the mill" state claims, P.App. at A-12, but concluded the case was outside this category.

A cause of action for alleged medical negligence in connection with a benefit determination is neither a "run of the mill" state law claim, nor a "generally applicable" cause of action that "functions irrespective of the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at 139. Thus, the Eighth Circuit's conclusion that ERISA preempts such a cause of action does not conflict with *Mackey*, and there is no basis to claim that the decisions are in conflict with one another.

C. As In Corcoran, Certiorari Is Not Warranted Here.

This Court recently denied the petition for certiorari filed in a case with issues similar, if not identical, to those present here. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992). In *Corcoran*, plaintiff's obstetrician placed her in a category of high risk pregnancy and ordered that she be hospitalized so that he could monitor the fetus around the clock. In accordance with the plan, the doctor sought precertification from the administrator for the participant's hospital stay. The administrator solicited a second opinion on the participant's condition from another obstetrician who advised that "the company would be at considerable risk denying her doctor's recommendation." *Id.* at 1322. Despite both doctors' recommendations, the administrator determined that hospitalization was not necessary and refused to precertify the hospitalization, instead authorizing payment for 10 hours per day of home nursing care. Upon learning that precertification was denied, the participant left the hospital and returned home. *Id.* at 1324. Less than two weeks after returning home, during a time when no nurse was on duty, the fetus went into distress and died. *Id.*

Plaintiffs in *Corcoran* filed a wrongful death action in state court, alleging that their unborn child died as a result of various acts of negligence by the plan administrator and others. Defendant removed to federal court pursuant to ERISA, and thereafter moved for summary judgment. *Id.* As here, plaintiffs argued that the plan administrator ("United") made medical decisions, not benefit determinations. The Fifth Circuit rejected this theory:

> In our view, United makes medical decisions as part and parcel of its mandate to decide what benefits are available under the Bell Plan. . . . When United's actions are viewed from this perspective, it becomes apparent that the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination. The nature of the benefit determination is different than the type of decision that was at issue in *Pilot Life*, but it is a benefit determination nonetheless. The principle of *Pilot Life* that ERISA preempts state law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here.

Id. at 1324. Concluding that "the central purpose of the lawsuit is to hold United liable for actions it took in connection with its duties under the plan," the Fifth Circuit affirmed the district court's grant of summary judgment against plaintiffs. *Id.* at 1334.

The same reasons why this Court denied the resulting petition for certiorari in *Corcoran* apply here. In this case, like *Corcoran*, petitioners seek to hold Lincoln National liable for actions taken in connection with its role as administrator of an ERISA plan. As in *Corcoran*, Lincoln National initially denied the participant's request for payment of benefits, and second opinions of physicians were reviewed in re-assessing the initial denial of benefit payments. Further, the policies in favor of applying ERISA's "unique preemptive force" are even stronger in this case. As opposed to the *Corcoran* plan administrator that did not necessarily rely upon an interpretation of the applicable ERISA plan when making its decisions, Lincoln National fully relied upon the restrictions and exclusions of the Belger Plan to determine whether the Plan provided benefits for a surgery to be performed by

non-participating doctors at a hospital outside the "Service Area." After concluding the Belger Plan did not provide benefits in such a situation, Lincoln National informed Barnes that it could not precertify the surgery.

Corcoran directly addresses, and rejects, petitioners' contention that Lincoln National provided "medical treatment" to Mr. Kuhl. Indeed, the *Corcoran* court ruled that medical decisions occur "in the context of making a determination about the availability of benefits under the plan," and therefore "relate to" an ERISA plan. *Id.* at 1311. Such a finding is further supported in this case, where petitioners allege Lincoln National provided "negligent medical treatment" to Mr. Kuhl without any evidence that Lincoln National provided any treatment to Mr. Kuhl at all.

If arguments such as those advanced by petitioners had any merit, this Court would have addressed them by granting certiorari in *Corcoran*, where essentially the same issues were presented for review. Just as *Corcoran* was consistent with prior Supreme Court precedent, thereby leaving no need for this Court to accept certiorari in that case, this case presents no novel legal issue warranting the grant of certiorari.

D. Federal Courts Consistently Rule That ERISA Preempts Wrongful Death Claims for Medical Malpractice.

Case law consistently establishes that ERISA preempts wrongful death claims. *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (5th Cir.), *cert. denied*, 113 S. Ct. 812 (1992); *Holmes v. Pacific Mut. Life Ins. Co.*, 706 F. Supp. 733 (C.D. Cal. 1989); *Settles v. Golden Rule Ins. Co.*, 715 F. Supp. 1021 (D. Kan. 1989), *aff'd*, 927 F.2d 505 (10th Cir. 1991). Petitioners are unable to cite a single case from any

jurisdiction in which a wrongful death claim arising out of plan administration was not preempted by ERISA, nor can petitioners distinguish their wrongful death claim from those preempted by ERISA in every other case to have addressed the issue.

A wrongful death claim with facts strikingly similar to the present case also was dismissed due to ERISA preemption in *Holmes v. Pacific Mut. Life Ins. Co.*, 706 F. Supp. 733 (C.D. Cal. 1989). In *Holmes*, the plan participant developed a liver disorder and made arrangements for surgery to be performed. The defendant insurance company erroneously affirmed that it provided coverage for the surgery. After arrangements for surgery had been made, the medical center called to verify that the insurer covered the cost of the surgery. This time the insurer answered that it did not. After a delay, the surgery was rescheduled. However, before another donor liver was available, the participant died. *Id.* at 734.

Plaintiffs filed a wrongful death action in California state court. Defendant removed to federal court and moved for summary judgment because ERISA preempted plaintiffs' state law claims, which were based entirely on representations made by the defendant acting in its capacity as the plan's administrator. *Id.*

The *Holmes* court reasoned that even if the state law in question is one of general application and is not designed to affect ERISA plans other than in an indirect manner, it is preempted if it is caught within ERISA's "expansive sweep." *Id.* at 736. The court also ruled that ERISA requires preemption of actions against plan administrators as well as plans themselves. *Id.* After granting defendant's petition for removal, the court dismissed all plaintiffs' causes of action.

In the present case, as in *Holmes*, a hospital which scheduled a surgery to be performed called the plan administrator to verify that benefits had been certified for surgery and was informed that the surgery was not a covered benefit under the plan. As in this case, the patient in *Holmes* died before the surgery could be rescheduled. Like Lincoln National, the defendant in *Holmes* made an assessment directly relating to benefits provided under an ERISA plan, and therefore the alleged causes of action are preempted by ERISA.

The Tenth Circuit Court of Appeals also ruled that a wrongful death cause of action was preempted by ERISA in *Settles v. Golden Rule Ins. Co.*, 715 F. Supp. 1021 (D. Kan. 1989), *aff'd*, 927 F.2d 505 (10th Cir. 1991). In *Settles*, after notification that his coverage was terminated by his ERISA plan administrator, plaintiff's husband allegedly suffered a heart attack and died as result of this notification. Plaintiff filed an action against her late husband's group health insurer, alleging causes of action (breach of contract, outrage, fraudulent denial of coverage, and wrongful death) similar to those alleged by petitioners in this case. The district court, relying upon ERISA preemption, granted defendant's motion to dismiss.

The Tenth Circuit ruled on appeal in *Settles* that ERISA preempted all plaintiff's claims:

> Here the injury alleged was a direct result of the termination of plan benefits and cannot be characterized as "wholly remote from the benefit plan" (citations omitted) . . . the factual basis for each of plaintiff's state law claims directly concerns the alleged improper administration of the benefit plan. Although plaintiff is not seeking benefits under the insurance policy, her claims

> require a finding that defendant wrongfully terminated Mr. Settles' insurance coverage. Therefore, the claims relate to the employee benefit plan.

Id. at 509.

Just as the *Settles* plaintiff claimed her husband's death was caused "as a direct consequence of defendant's action in terminating her husband's health insurance," *id.* at 507, petitioners claim Mr. Kuhl's death was caused as a direct result of Lincoln National's actions. In the present case, as in *Corcoran, Holmes* and *Settles,* the injuries alleged by petitioners are a direct result of supposed improper handling of Mr. Kuhl's claim for payment of benefits to cover his contemplated surgery. Petitioners have not cited a single case holding to the contrary and Lincoln National has not found any such case. Every applicable case leads to the conclusion that federal courts have resolved this issue identically each time it is raised, and there is no reason for the Court to grant certiorari here.

E. The Eighth Circuit's Decision Furthers The Purposes Behind ERISA's Preemption Provision.

In *Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063 (1993), this Court recently expressed its reluctance to tamper with the delicate balance crafted by Congress when enacting ERISA:

> There is, in other words, a "tension between the primary [ERISA] goal of benefitting employees and the subsidiary goal of containing pension costs." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 515 (1981); *see also Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985); we will not attempt to adjust the balance between those competing goals that the text adopted by Congress has struck.

Id. at 2072. By seeking reversal of the lower courts, petitioners invite this Court not only to disrupt the statutory scheme adopted by Congress, but also to undercut substantial precedent interpreting ERISA since its enactment. Criticisms of ERISA's preemptive scope should be addressed to Congress and not this Court.

In enacting ERISA, Congress intended that "plans and plan sponsors would be subject to a uniform body of benefit law" and not subject to the "burdens of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). The Eighth Circuit's ruling furthers this purpose by avoiding a decision that could lead to the variant regulatory schemes Congress sought to avoid. State laws that subject plans to inconsistent regulations in different states, thereby increasing inefficiency and potentially causing the plan to respond by reducing benefit levels, consistently are preempted by ERISA. *See Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1333 (5th Cir.) *cert. denied*, 113 S. Ct. 812 (1992). As this Court stated in *Ingersoll-Rand*:

> It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.

498 U.S. at 143. Similarly, there is a significant risk that state liability rules would be applied differently to the conduct of utilization review companies in different states. The cost of complying with varying substantive standards would increase the cost of providing utilization review services and ultimately would decrease the pool

of plan funds available to reimburse participants. *See Corcoran*, 965 F.2d at 1333.

A plan administrator that makes a commitment to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, monitoring the availability of funds for benefit payments, and other tasks. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide claims processing and benefit disbursement. However, such a system is difficult, if not impossible, to achieve if a plan administrator is subject to liability beyond what is set forth in ERISA.

Clearly, if plan administrators are subjected to state law claims, the resulting costs will be passed on to plans in the form of higher fees and lower benefits, all to the detriment of the vast majority of persons covered by the plans. With the national crisis facing this country in connection with health care and its costs, the balance struck by Congress in preempting claims such as those asserted by petitioners in this case ultimately benefits all plan participants. Subjecting a plan administrator to such uncertainty introduces inefficiencies and vulnerabilities that ultimately lead to reduced benefits in existing plans, and to certain plan administrators refraining from offering benefits at all. *Shaw*, 463 U.S. at 104.

Recognizing the threat of such uncertainty, Congress intended ERISA's preemptive scope to shield ERISA plan administrators from unforeseen liabilities. This is critical to the entire statutory scheme. H. R. Rep. No. 533, 93rd Cong. 1st Sess. 8, reprinted in 1974 U.S. Code Cong. & Admin. News 4639, 4646. Congress' comprehensive legislative scheme, including an integrated system of procedures for enforcement, is implicated in this case. It is

not for the courts to disturb the balance Congress determined appropriate. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985).

F. The Eighth Circuit Correctly Ruled That ERISA Preempts Petitioner Mary Kuhl's Emotional Distress Claim.

Petitioners attempt to rely on one circuit court case, *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821 (1st Cir. 1988), *cert. denied*, 488 U.S. 909 (1988), which purportedly conflicts with decisions of other circuit courts as to whether emotional distress claims are preempted by ERISA. *Drinkwater* is distinguishable under the law and on its facts.

While *Drinkwater* did not preempt the emotional distress cause of action alleged in that case, the court nevertheless entered summary judgment because plaintiff neither alleged nor established that she suffered any injury to support her emotional distress claim. *Id.* at 826. Therefore, the language relied upon by petitioners in *Drinkwater* addressing ERISA is *dicta* at best.

Further, the failure of the *Drinkwater* court to recognize ERISA's preemption of claims for emotional distress places it directly at odds with virtually every other court which has addressed this issue. *See Powell v. Chesapeake and Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Johnson v. District 2 Marine Eng'rs Beneficial Assoc.*, 857 F.2d 514 (9th Cir. 1988).[8] In

---

[8] *See also Meyer v. Employers Health Ins. Co.*, 722 F. Supp. 547 (E.D. Wis. 1989); *Rollo v. Maxicare of Louisiana, Inc.*, 698 F. Supp. 111 (E.D. La. 1988); *Pane v. RCA Corp.*, 667 F. Supp. 168 (D.N.J. 1987), *aff'd*, 868 F.2d 631 (3d Cir. 1989); *Smith v. Electronical Data Sys. Corp.*, 657 F. Supp. 1242 (D. Colo. 1987); *Folz v. Marriott Corp.*, 594 F. Supp. 1007 (W.D. Mo. 1984).

Powell, a case cited by both the Eighth Circuit and the district court, plaintiff brought a claim for intentional infliction of emotional distress against her former employer and her former benefit plan. The Fourth Circuit ruled that ERISA preempted plaintiff's claim:

> In this case, none of the state laws under which (plaintiff) claims relief have any intrinsic connection with employee benefit plans. The question is therefore whether state law claims which relate to the administration of an ERISA-governed plan, but which arise under general state laws, which themselves have no impact on employee benefit plans, are within the scope of ERISA preemption. Given the "unparalleled breadth of the preemption clause," *Holland v. Burlington Indus., Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), and the broad remedial policies of ERISA, we hold that state laws, insofar as they are invoked by beneficiaries claiming relief for injuries arising out of the administration of employee benefit plans, "relate to" such plans and, absent an applicable exemption, are preempted by ERISA.

Powell, 780 F.2d at 421. The application of ERISA's broad preemptive scope in *Powell* to claims against an HMO that are identical to those of petitioners' here provides additional support for the Eighth Circuit's ruling.

II. THE COURT OF APPEALS PROPERLY CONSIDERED THE EVIDENCE IN AFFIRMING THE DISTRICT COURT'S GRANT OF LINCOLN NATIONAL'S MOTION FOR SUMMARY JUDGMENT.

A. There Exists No Issue Of Material Fact.

In reviewing the district court's decision to grant summary judgment, the court of appeals properly considered

all evidence in the light most favorable to petitioners. Both the court of appeals and district court carefully reviewed both the factual and legal arguments raised by petitioners. These courts determined there was no genuine issue of any material fact and no merit to petitioners' legal position.

Petitioners' argument that these courts improperly reviewed the case from a factual standpoint fails to consider what facts actually are material to Lincoln National's motion for summary judgment. As set forth in *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986):

> The mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact. Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude summary judgment. Factual disputes that are irrelevant or unnecessary will not be counted.

Id. at 247-48 (emphasis in original). In this case, there is no dispute that petitioners' decedent, Buddy Kuhl, was a Belger employee, that Mr. Kuhl was a participant in the Belger Plan, that Lincoln National was the administrator of the Belger Plan, and that the Belger Plan is both an "employee benefit plan" and an "employee welfare benefit plan" within ERISA. Further, there is no dispute that Barnes Hospital was not within the "Service Area" for the Belger Plan, or that Lincoln National was not obligated under the Belger Plan to pay for services rendered outside the "Service Area" or for medical services rendered by doctors not participating in the Lincoln National network. More fundamentally, there is no dispute that whatever Lincoln National is alleged to have done, it took all actions in connection with its role in determining benefits under an ERISA plan. Therefore, although Lincoln

National takes issue with many of the factual characterizations made by petitioners, none of the facts material to ERISA's application have been disputed. The courts below correctly ruled that ERISA preempts petitioners' claims.

B. The District Court's Ruling Was Correct.

The district court set forth an exhaustive analysis of the applicable facts, law and the appropriate standard for summary judgment in its order. The district court was well aware of the burden imposed upon a party moving for summary judgment:

> In ruling on a motion for summary judgment, it is the court's obligation to view the facts in the light most favorable to the adverse party and to allow the adverse party the benefit of all reasonable inferences to be drawn from the evidence. *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 157 (1970); *Inland Oil and Trans. Co. v. United States*, 600 F.2d 725, 727-28 (8th Cir.), *cert. denied*, 444 U.S. 991 (1979). . . . A genuine issue of material fact exists "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 106 S.Ct. 2505, 2510 (1986) . . . The inquiry to be made mirrors the standard for a directed verdict: whether the evidence presented by the party with the onus of proof is sufficient that a jury could properly proceed to return a verdict for that party. *Anderson v. Liberty Lobby* at 2511.

P.App. at C-7, 8.

Far from ignoring the appropriate summary judgment standard, the district court took great pains both to set forth the appropriate standard in its order, and to apply that standard to the facts of this case.

Additionally, six months after initially granting Lincoln National's motion for summary judgment, the district court entertained oral argument to further insure that petitioners' arguments had been thoroughly analyzed. During the oral argument, the district court again studied all factual and legal arguments raised by petitioners and again dismissed their claims. Thus, petitioners' contention that the district court erred in reviewing the evidence ignores the painstaking steps taken by the court to do exactly that.

C. The Eighth Circuit's Ruling Was Correct.

The court of appeals also applied the correct standard in reviewing the district court's grant of summary judgment. The court of appeals expressly recognized its obligation to view all inferences from the facts in the light most favorable to petitioners. Even doing so, however, the court of appeals ruled Lincoln National was entitled to summary judgment:

> Taking the facts in the light most favorable to the Kuhls, as we must for purposes of Lincoln National's motion for summary judgment, we are compelled to agree with the district court. .

P.App. at A-11.

Petitioners claim that the Eighth Circuit was disingenuous by "repeating the maxim" regarding the standard for summary judgment but then "flatly reject[ing] the facts averred by the Kuhls." Petitioners' Brief at 23. Not only does petitioners' argument improperly disparage the court of appeals, it also has no basis in law or fact. The lower court properly focused on those facts material to Lincoln National's motion for summary judgment, and correctly ruled there was no dispute as to any such fact. While petitioners make much of the testimony

of Dr. Levi, the Eighth Circuit correctly noted that there is no evidence that Mr. Kuhl sought medical treatment from Lincoln National at any time. Further, the court's review of the record made "clear that [Mr. Kuhl] was not under the misconception that Lincoln National had taken the place of his treating physicians. . . . " P.App. at A-12. This additional finding demonstrates that the court of appeals properly considered all evidence and correctly affirmed the judgment of the district court.

CONCLUSION

For the reasons stated herein, the Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit by Petitioners Mary Kuhl, Buddy Kuhl, Jr. and Marnie K. Kuhl should be denied.

Respectfully submitted,

MARK E. JOHNSON
R. CHRISTOPHER ABELE
TERRY L. TYRRELL
WILLIAM E. HANNA
MORRISON & HECKER
2600 Grand Avenue
Kansas City, Missouri 64108-4606
(816) 691-2600
(FAX) 474-4208

Attorneys for Respondent
Lincoln National Health Plan
of Kansas City, Inc.